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POSITIVE SOCIAL SUPPORT NEWSDIGEST

A "BEING ALIVE" PROGRAM

For people who are HIV positive and for those who are supportive

Cancellation of International Conference at Harvard

BOSTON -- (AP) Harvard University announced it would move an international AIDS conference overseas next year, blaming the decision on a ban of AIDS-infected foreigners from entering the United States.

The Harvard AIDS Institute said the 8th Annual International Conference on AIDS, scheduled to be held in Boston next May, probably would be moved to a European city. The new site was expected to be announced within a month.

"This is a clear statement that we don't feel comfortable with the policy and can't go ahead with it in place," institute chairman Max Essex said.

Asked about the decision to cancel the conference, President Bush said, "They'll find other ways to get together."

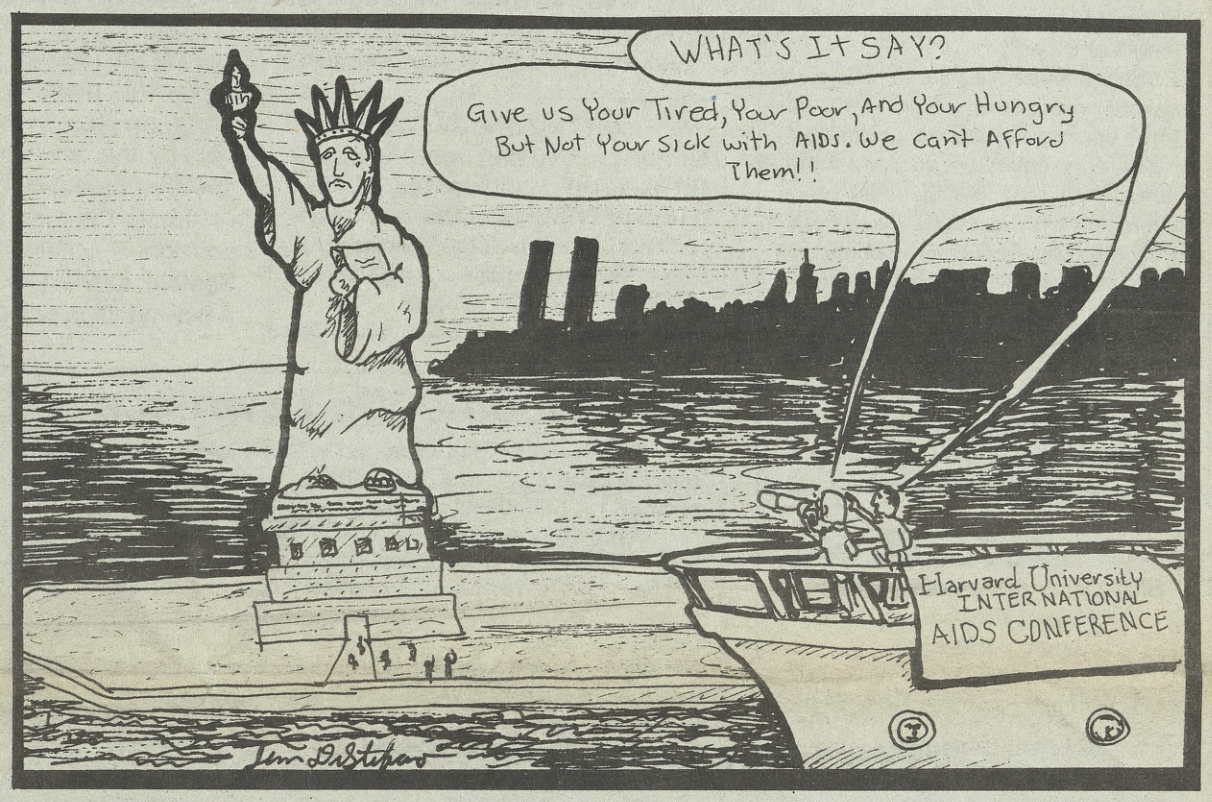
Essex, saying he was personally frustrated by problems that prompted the move, also announced that he would step down as organizer of the forum, the largest gathering of AIDS authorities in the world.

Jonathan Mann, head of the institute's International AIDS Center and former head of the World Health Organization's global program on AIDS, was named his successor.

"I always felt comfortable leading a conference that would concentrate on the science of AIDS," Essex said. "But I don't think I was aware of how much one would need in the way of diplomatic and political skills to hold a conference in this country."

The rule barring AIDS-infected individuals from the United States was imposed four years ago but was temporarily suspended during the conference last year in San Francisco.

In January, Health and Human Services Secretary Louis Sullivan sought to drop AIDS from the list June 1. But the Justice Department and other agencies objected, and federal health officials received about 40,000 letters, 90 percent opposed to dropping AIDS from the list.



CDC Revises AIDS Diagnosis Guideline

by Arturo Jackson III
HIV/AIDS Editor
the latest ISSUE

HIV-positive individuals with T4 helper cell counts less than or equal to 200 will meet newly revised AIDS diagnosis guidelines being implemented by the Centers for Disease Control in January 1992.

The current CDC AIDS definition, last revised in 1987, is based primarily on the clinical disease syndromes identified and reported manifesting in thousands of HIV immune suppressed gay men over the past 10 years. The revised AIDS guidelines will measure the degree of immune suppression by the extent of T4 helper cell loss and will no longer rely solely on clinical disease diagnosis.

"This allows cases to be reported at the first laboratory sign of severe immunodeficiency," stated Dr. James Curran, director of the AIDS division at the agency's National Center for Infectious Diseases. "That's the time when people are in severe need of medical care and services," the director added.

See CDC on page 12

The 7th International Conference on AIDS

by Arturo Jackson III
HIV/AIDS Editor
the latest ISSUE

The 7th International Conference on AIDS held in Florence, Italy June 16-21, united over 9,000 researchers intent on understanding gains made in the treatment of HIV over the course of the past year.

While there were no bombshell revelations, significant steps in understanding the mechanism of the HIV virus and subsequent disease manifestations were presented to conference attendees.

Results of clinical trials monitoring the effectiveness of potential treatments reported on both failures and successes in those which demonstrated an ability to extend as well as improve the quality of life for people with HIV/AIDS.

The researchers represented over 80 nations. The conference theme entitled "Science Challenging AIDS" highlighted the almost exclusive emphasis on science at this year's international meeting. "The momentum of human efforts against diseases must move from science to policy and not vice versa," states conference Chairman Fernando Dianzani, voicing an opinion shared by many of the conference organizers.

The 7th International Conference on AIDS provided a forum highlighting the latest information culminated by the scientific community in our race against the onslaught of the AIDS epidemic. The lack of scientific breakthroughs led to an announcement by conference organizers that all future conferences except those already scheduled will be held every other year instead of annually.

Berlin will host the 1993 conference and Japan, in 1994.

The following are highlights from this year's conference:

AZT Therapy for Asymptomatic People

San Francisco physicians presented follow-up research data from ACTG 019, a placebo-controlled research trial monitoring the effects of AZT (zidovudine) in asymptomatic HIV+ individuals. The trial was halted in 1989 after study volunteers taking the placebo compound experienced consistent decline in immune function while the health status of a majority of study participants given AZT stabilized.

In subsequent testing of participants in the ACTG 019 trial, Paul Volberding, professor of medicine at the University of California, San Francisco and director of the AIDS program at San Francisco General Hospital reported that AZT therapy appears to be a safe option for HIV+ asymptomatic individuals.

The professor stated that even after several years of AZT therapy, the 500-milligram dosage level of the drug was safe with no new types of toxicity observed. On the issue of AZT-resistant viral strains, the professor stated, "all the evidence shows that high-level drug resistance is very uncommon if it happens at all, even after

See Conference on page 12

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* The Editors reserve the right to refuse any submitted material for any reason.
* Submitted materials may be edited for length and clarity.
* PSSN reserves the right to refuse sexually explicit ads. Ads will run for three consecutive issues, unless cancellation is requested prior to publication of third issue. All ads must be resubmitted after each three-issue run.
* Editorial policy is subject to change at the discretion of the Editorial Board.

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Circulation 4,000

LAMBDA Center Awarded $114,500 AIDS Grant

by Franklin John Kakies
Director AIDS Response Programs

The LAMBDA Community Center has successfully completed its 1990-91 AIDS Education and Prevention Grant from the County of Sacramento, and has been awarded $114,500 for fiscal year 1991-92, an increase of 10 percent over the previous year.

The increase in funding is directly tied to the success of AIDS Response Programs at the Center.

With a directive from the County to provide AIDS Education to gay and bisexual men, LAMBDA has met or exceeded its goals handsomely, in some cases by more than four-fold.

Programs continuing under the new Grant include Youth Group, Coming Out Group, Being Alive Living room, the "Keeping It Up!" workshop, publication of the *Positive Social Support Newsdigest (PSSN),* and the incredibly successful AIDS Outreach Program. In addition, the new Grant provides for an outreach program directly targeting Youth (specifically those engaging in same-sex activity) as perhaps the fastest growing at-risk group.

Staff changes under the new Grant include the following: the promotion of senior staff member Franklin Kakies to Program Director, the position formerly held by the late Tim Warford, this by specific request of the County. Staying on to fill the newly-created full-time position of Health Educator is Craig Spatola, formerly Outreach Organizer. A new addition to the team will be John Rambo, joining the AIDS Response staff as Programs Organizer/Administrative Assistant. Finally, continuing on as integral parts of the AIDS Outreach team are Ron Rosenblatt (aka Sacramento's fabled and beloved 'Condom Contessa') and John Hylton, Senior Outreach Coordinator.

Past and present staff and volunteers are to be commended for the fine job they have done over the past year in helping to carry out this important work. The LAMBDA Community Center would particularly like to thank the County AIDS Unit for its incredible support and assistance in facilitating the implementation of the AIDS Education and Prevention Grant.

Our goal at the LAMBDA Community Center in 1991-92 is to continue developing the AIDS Response Programs, making them stronger and more successful than ever before. To this end we say "Thank you Sacramento!" for your continuing support and attention.

Correction

In the Co-Editors' column in the July/August issue of *PSSN*, the name of Robert Becker was omitted from the list of early contributors. We apologize for the oversight.

Welcome, Dr. Lawrence

PSSN is pleased to welcome Dr. Ruth Lawrence as the new medical consultant. She succeeds Dr. Elizabeth Harrison who relocated to Minnesota in June.

Dr. Lawrence is an Associate Professor of Clinical Medicine with the University of California Davis, School of Medicine. She is board certified in both internal medicine and infectious diseases. She has been associated with the AIDS and Related Disorders Clinic at UCDMC since 1987, first as a volunteer clinical faculty and for the past 18 months as a full-time physician with the clinic working with Dr. Neil Flynn. Dr. Lawrence also is the Director of the AIDS In-patient Unit at UCDMC and the AIDS Consult Service for the hospital.

We look forward to working together with Dr. Lawrence.

Premiere Benefits PSSN

LAMBDA Community Center's AIDS Response Programs in conjunction with Tower Theatre and WCIC/Project Survival, presented a benefit premiere of the movie *Paris is Burning,* on Thursday, August 8.

Over 400 people attended the buffet and movie, and at $10 a ticket that made for the most successful one-night fundraiser in the history of the AIDS Response Programs. *PSSN* will be one of the recipients.

Kudos to Matias Bombal for his flawless performance as Emcee Gerry Watt, Jo Babbett, and staff of the Tower Theatre, French Maids Rick Scholl and Gerry Savina, Nadine Roberts, Staff and Volunteers at WCIC, Franklin Kakies, Craig Spatola, Staff and Volunteers at LAMBDA Community Center and, last but not least, ovations to Catering for the wonderful buffet!

Study offers clue to why AIDS causes malnutrition

by Nancy Vogel

Researchers at the University of California, Davis, Medical School announced a discovery Saturday that helps explain why malnutrition plagues AIDS patients in the early stages of the disease.

Nutrient-absorbing cells in the small intestine can be attacked by HIV, the AIDS virus, six researchers with the school's department of internal medicine reported in the latest issue of Gastroenterology.

The researchers said these HIV attacks lead to decreased activity of digestive enzymes, poor absorption and eventual malnutrition.

The research may help advance understanding of the intestine's role in AIDS and lead to specific treatments for malabsorption and malnutrition, the researches said.

All nine HIV-positive patients studied showed abnormalities in intestinal absorption tests, enzyme tests or intestinal biopsies. And researchers found the AIDS virus in the small intestines of five of nine patients.

"We were quite surprised by the finding because we didn't expect to find the virus in these cells," said co-author Satya Dandekar, associate professor of internal medicine at UC Davis.

Another significant aspect of the findings is that HIV attacks intestinal cells early in the disease, said Dandekar.

"The patients who are infected with HIV do have malabsorption, and malabsorption can occur very early in the disease before you have full-blown AIDS," said Dandekar.

Exactly how HIV infection disrupts absorption is not yet known, she said.

"Once we know the mechanism, it would be helpful to design any kind of prevention by targeting those cells," said Dandekar.

The findings raise many other questions, such as whether the stage of the disease has anything to do with which cells are infected, she said.

The study was financed by the UC AIDS Task Force and the National Institutes of Health's clinical nutrition research unit.

-- The Sacramento Bee

Potluck
Pool Party
Sunday, Sept. 15
Noon to ?
3624 Folsom Blvd.
(Park on 36th or 37th, not in the alley)
Water Volleyball, weather permitting
BYO Beverage and Meat to Barbeque
For details, call Mike Kelly (456-1610)

HIV Infection in Women

by Howard Minkoff, MD
and Jack A. Dehovitz, MD, MPH

Over 10 percent of the nation's AIDS cases have occurred among women, and the percentage increase in new AIDS diagnoses among women is growing at a faster rate than among men. If current trends continue it is estimated that AIDS will be the fifth leading cause of death among women of reproductive age in the United States by the end of this year (Chu). By 1987 AIDS was already the leading cause of death of reproductive-age minority women in New York and New Jersey. Although a great deal is known about HIV disease in men and children, relatively little has been published about the disease in women, aside from reports on pregnant women and their role in perinatal viral transmission. Given the increasing burden that HIV disease presents to the health of women, and the unique ways in which the disease may affect them, there is a clear need to learn more about HIV disease in women.

It is probable that gender influences both the course of HIV infection and the impact of infection on general health. Endogenous and exogenous hormones, for example, could influence the natural history of HIV disease since both estrogen and progesterone affect the immune system. In addition, HIV infection could affect the natural history and response to therapy of both infectious and neoplastic gynecologic diseases. Finally, gender may make it more difficult for HIV-infected women to access the medical care needed to slow the progression of disease, or to enter clinical trials.

Clinical Manifestations

There is no specific evidence that the clinical course of HIV infection in women differs from that in men; however, the initial cohort studies that defined the natural history of HIV infection have been conducted exclusively in men. While early studies suggested that women with AIDS may have a poorer prognosis than men, subsequent studies have not confirmed this. Some of the differences reported initially may have reflected the overrepresentation of drug users among HIV-infected women.

Additionally, no specific studies have been done to determine whether the range of non-gynecologic opportunistic manifestations of HIV disease differs between men and women.

Candida Vaginitis: Gynecologic manifestations of HIV disease are of particular importance. Several studies have documented a high rate of candida vaginitis in HIV-infected women.

Squamous Intraephithelial Neoplasia: The sexually transmitted infection that may have the greatest clinical consequence for HIV-infected women is human papillomavirus (HPV), the causative agent of squamous intraepithelial neoplasia. Neoplasia induced by viruses, such as non-Hodgkin's lymphoma (associated with Epstein-Barr virus), and squamous-cell neoplasia (associated with HPV), occurs more frequently and with an accelerated natural history in immunosuppressed patients.

It is reasonable to anticipate an association between HIV and HPV infections. Both viruses are sexually transmitted. HPV in particular is quite common among sexually active women, with the reported prevalence ranging up to 50 percent.

Cervical Disease: Recent reports have suggested an association between HIV infection and cervical disease in women. The rate of abnormal Papanicolaou (Pap) smears was as much as 11 times greater among HIV-infected women in these studies.

Complicating the diagnosis of cervical disease in HIV-infected women is uncertainty about the diagnostic accuracy of standard cytologic evaluations in HIV-infected women. The possibility exits that cervical colonization with certain organisms might lessen the reliability of Pap smears (Maiman, personal communication). Confirmatory data are needed.

Pelvic Inflammatory Disease: PID, like cervical intraepithelial neoplasia (CIN), is caused by sexually transmitted diseases, and a high prevalence of PID among HIV-infected women would therefore not be unexpected. PID is a major public health problem in the United States, affecting one million women annually and costing a billion health-care dollars. The sequelae of PID include infertility, chronic pelvic pain, and ectopic pregnancy. Relatively little is known about the impact of HIV infection on the course of PID.

Genital Ulcers: Recently, intractable genital ulcers have been described in three HIV-infected women at Covino. Extensive laboratory workup ruled out syphilis, chancroid, and herpes simplex infection. Extensive laboratory workup ruled out syphilis, chancroid, and herpes simplex infection. In addition, the lesions failed to respond to standard therapy for those established causes of genital ulceration. Histologic examination of the lesions revealed acute and chronic inflammation, granulation tissue, and moderate dysplasia. The lesions did respond to zidovudine therapy, which in concert with the nonspecific histologic findings suggest that these ulcers may be a primary manifestation of HIV infection.

Current Standards for Gynecologic Care

Preliminary data suggest that the clinical manifestations of gynecologic disease may indeed be altered by HIV

*See **Women** on page 14*

Culture May Limit AIDS Prevention Measures

STATE COLLEGE, PA -- (AP) Cultural practices that may expose a major portion of the Native American population to AIDS and the HIV virus may also limit prevention measures, according to a Penn State study.

The study, conducted by Dr. L.A. Napier assistant professor of education, and Dr. G. Mike Charleston, associate professor of education, is titled "An Indian Plan for Addressing AIDS Education for Out-Of-School and College-Aged Indian Youth for the Centers for Disease Control and the Indian Health Service." Its objective was to determine the best way to get AIDS prevention knowledge to American Indian out-of-school youths.

"The study reveals that Acquired Immunodeficiency Syndrome is on the increase among American Indians, that cultural practices may contribute to that increase, and that Indian versus non-Indian cultural pressures and high numbers of school drop-outs make implementing preventative education programs especially difficult," Napier said.

According to the study, 56 percent of Native American males with AIDS and 70 percent of the females were under age 35 in 1989. In comparison, only 21 percent of all U.S diagnosed AIDS cases have been people between the ages of 20 and 29.

"The spread of AIDS may become prominent among young Native American Indians because they make up the largest segment of the Indian population," Napier said.

As America's smallest minority group, Native Americans comprise 0.8 percent of the U.S. population, according to the 1990 U.S. Census, but about 64 percent of the group consists of individuals under age 30. Of the total U.S. population, 50 percent is under age 30.

In November 1989, only 150 American Indian AIDS cases were reported, but the number was up nearly 90 percent over the 80 cases reported in October of the previous year. As of April 1991, about 248 American Indian AIDS cases have been reported.

The study suggests that preventative

*See **Culture** on page 15*

For Good Advice, Go To Helena Handbasket...

Dear Miss Handbasket:

I've recently moved in with my lover of two-and-a-half years. I am HIV+ and have been for at least six years. Initially, I was afraid to disclose my HIV status, but opened up to him after he was hospitalized for Pneumocystis Pneumonia.

My problem is that while our relationship is growing intellectually, sexually it is going nowhere. Although we both appreciate having someone to sleep next to at night, my sex drive is increasing, while his seems to be decreasing. I really don't wish to seek sexual fulfillment outside of our marriage, but I'm at my wits end. How can I communicate my sexual desires without sounding like a sex-starved hound?

Sincerely,

Howling at His Moon

Dear Howling,

Miss Helena empathizes with your frustration. She would suggest, however, that you yourself have identified the necessary first step, which is to begin some sort of dialogue.

You don't say in your letter whether you have tried communicating your sexual desires or not. I have often noticed a tendency for us to expect our loved ones to be mind readers -- especially when it comes to fulfilling our sexual needs. What is wrong with sounding like a sex-starved hound if you are one? In or out of bed, you are entitled to ask for what you want. More than that, it is ultimately your responsibility to make your needs and wants known. Is it possible that one or both of you suffers from some sort of residual guilt about sex? Sex is an inherently health activity, contrary to the mixed messages our highly sexphobic (not to speak of homophobic) culture is continually sending us.

If you haven't already done so, make a time to sit down and talk to your lover. Choose a time when neither of you is too tired, or preoccupied with other problems, and then try to be as honest and direct as you can manage to be: in fact, you might negotiate that as a condition of having the discussion.

Miss H. has noticed that sometimes two gay men will fall into that more typically 'male/female thing' where one person becomes the pursuer, wanting more intimacy, more communication, more connection:

*See **Helena** on page 15*

Peptide T: Major Study Recruiting in Los Angeles

by John S. James

A controlled trial of peptide T, an experimental treatment which some researchers believe may be helpful in treating neurological effects sometimes caused by AIDS, is now seeking at least 150 volunteers. This one-year trial, jointly sponsored by the U.S. National Institute of Mental Health and the U.S. National Institute of Allergy and Infectious Diseases, will be run at a single site, the University of Southern California School of Medicine, Los Angeles County USC Medical Center.

For the first six months on the trial, half of the patients will receive a placebo; the others, peptide T. But during the final six months there will be no placebo, so everyone will receive the drug. Peptide T will be taken by nasal spray; the dose will be two mg three times a day.

Volunteers will be allowed to use any FDA-approved medications for prevention or treatment of opportunistic infections, and they may also continue treatment with AZT or other antivirals if they are taking them when they begin the study. Also, it is OK to start a new antiviral treatment after the first six months. So that accurate data will be collected, it is important that volunteers not use recreational drugs, sleeping pills, or tranquilizers during the study, and refrain from alcohol for 48 hours prior to the monthly appointments for tests. And volunteers must not have taken drug treatment for a psychiatric problem within four weeks of starting the study, or have taken Prozac (a longer-lasting tranquilizer) within eight weeks.

Because this study will look mainly for neurological and cognitive improvements, it is seeking volunteers who are HIV positive and have problems with concentration or memory (for example, frequently losing keys or wallets, or forgetting why one came into a room). Yet these symptoms must not be too severe, because volunteers must be able to complete a battery of neurocognitive (tests of mental functioning) in order to enter the study, and these tests can be somewhat difficult for anyone.

Participants may have any T-helper count. They need to have enough fluency in English to take the neurocognitive tests used in the study.

Exclusion criteria include frequent need for hospitalization or other serious underlying medical problems, more than 10 KS lesions, pregnancy, or current use of cocaine, heroin, or marijuana. There are various scientific reasons for these exclusions. For example, a person with serious KS will be likely to need chemotherapy before the study ends, and chemotherapy can affect performance on the tests used in this trial, and therefore affect the data and the study results.

Each participant will require tests on three days at entry to the study. No hospitalization or overnight stay will be required; however, it is possible to stay overnight at the medical center, for persons from outside the area who want to avoid the cost of a hotel. Later, monthly visits (each requiring about two and a half hours at the clinic) will continue for 12 months. Two lumbar punctures will be required -- one at entry to the study, and the other at six months. (Special very fine needles are used, to reduce the possibility of post-tap headache.) And tests of the cerebrospinal fluid -- for syphilis, cryptococcal meningitis, and toxoplasmosis -- provide the participant with valuable diagnostic information. The six-month appointment will also include a skin test, which takes 48 hours before it can be read; therefore two visits, 48 hours apart, will be required at that time.

Volunteers need not live in the Los Angeles area; however, the study is not able to pay for their transportation. It is important that those entering the study be able to stay with it for the one year period.

If this trial shows that peptide T is effective, then "best effort" will be made to obtain it for the volunteers after the study is over, until the drug is commercially available. However, no guarantees of access after the trial can be given.

For more information about volunteering for this new trial, call Bob Herr, at the University of Southern California Medical Center, (213) 226-4643.

-- AIDS Treatment News

Unimed Capsules Favored for AIDS

by Iris Taylor

Unimed Inc. of Somerville got a boost when the federal government said doctors should first treat AIDS weight loss patients with its anti-nausea capsules, Marinol, before prescribing marijuana cigarettes.

Marinol, approved in the United States as a cancer anti-nausea product, is entering Phase 3 clinical trials to determine its efficacy as an AIDS appetite stimulant. Unimed is pinning its hopes on a supplemental approval for that indication, saying it would vastly expand Marinol's market and lead the company to profitability.

As a result, FDA approvals of marijuana cigarettes have swelled to 34 patients. "They need to grow an additional one-and-a-half acres of supply," said William Grigg, spokesman for the U.S. Department of Health and Human Services' Public Health Service agency. "The agency met and discussed the problem and felt the best thing to do would be not to provide marijuana to additional patients, at least initially, but to encourage them to use THC first."

THC has not been approved for AIDS weight loss, But, the government was concerned that "natural marijuana may have contamination aside from the active ingredient, and nobody knows how harmful it would be to an AIDS patient's immune system." THC refers to delta-9-tetrahydrocannabinol, the active component of marijuana in Unimed's Marinol.

The Public Health Service Agency stated, "whenever possible we should use THC, which is reliable, effective and much less harmful, instead of marijuana.

The Public Health Service statement is not an endorsement of Marinol, but patients are going to try an experimental product, at least try one that is purified and controlled.

Marinol, unlike marijuana cigarettes, does not induce euphoria. Doctors must apply for permission through the National Institutes of Health (NIH) to use Marinol for uses other than cancer chemotherapy-induced nausea.

Unimed has reported data from a 31-patient, Phase II California study which found that Marinol stimulated appetites and caused weight gain in 61 percent of the trial's evaluable AIDS patients. It said if AIDS patients' appetites can be stimulated, their quality of life and life expectancy can be enhanced.

Unimed's Phase III trials will involve over 100 patients and between 10-15 centers nationwide. He said the sites have been established, initial meetings have been held with clinical investigators, and the first patients will begin treatment in the next several weeks.

-- Star Ledger

ddI Receives Federal Panel's Recommendation for FDA Approval

by Arturo Jackson III
HIV/AIDS Editor
the latest ISSUE

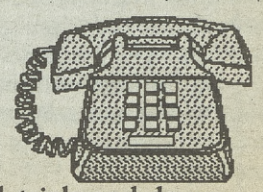
Experimental AIDS drug ddI (Dideoxyinosine) was recommended for FDA approval by a federal advisory panel for individuals with HIV infection no longer benefiting from or able to tolerate AZT.

Following two days of hearings, the Food and Drug Administration's Antiviral Drug Advisory Committee announced its opinion on July 19 based on "surrogate markers." The panel members hope that these markers will ultimately prove to be accurate indicators of potential drug's effectiveness and validate the innovative federal drug approval process implemented by the panel's recommendation regarding ddI.

The panel members based their recommendation on research findings which indicated that ddI initiated a rise in CD4 cells, also known as T4 helper cells in ddI study participants when compared with study volunteers taking AZT. The drug ddI is similar in chemical structure to AZT, the only FDA approved antiviral AIDS drug. Potential serious side effects associated with ddI include painful nerve damage to the feet and pancreatus, an inflammation of the pancreas. In almost all cases, the side effects are reversible upon early detection and stopping treatment with the drug. Serious significantly different side effects associated with AZT include anemia and abnormally low white blood cell counts, upon approval ddI will offer those no longer able to take AZT a viable treatment option. According to the FDA, "the committee felt that the data, when combined with the gravity of the AIDS crisis and the fact, that no drug is approved for AIDS patients unable to take AZT, warranted approval for the drug," stated an FDA spokesperson.

In making its recommendation, the committee urged the initiation of further studies of ddI to further document the drug's effectiveness. In the United States, more than 20,000 individuals have received ddI through "expanded access" trials and in excess of another 2,500 individuals have received the drug in traditional clinical studies. "If there is no efficacy of the drug, the agency would withdraw it," FDA Commissioner David Kessler stated to the panel members. The spokesperson stated he was unsure when the FDA would formally approve ddI but promised that the agency would "act quickly."

AIDS Clinical Trials Information Service



The AIDS Clinical Trials Information Service (ACTIS), sponsored by the U.S. Public Health Service, offers up-to-date information on federally and privately sponsored HIV/AIDS clinical trials and drugs used in the trials. To access the service call 1-(800)-TRIALS-A.

Living with AIDS: A Wife's Story

by Katie Bias

I've been asked to speak to you about how having AIDS has affected my life. This is an overwhelming task since AIDS has impacted virtually every part of my life -- as would any major illness.

My experience is in some ways NOT indicative of the "typical AIDS experience" --if there is such a thing. I believe I've been very fortunate in my expeience -- from having wonderful support of my family and friends to discovering something inside me, (instilled by my parents, perhaps?) that has permitted me to be stronger than I would have thought possible. My experience would also indicate that in an environment that is compassionate, nonjudgmental and educated, it is possible to live a full life with this disease -- possibly even survive.

In some ways, though, my experience is very similar to others I've met: dealing with issues of health and wellness, guilt and shame, living and dying; making sense of the medical system and insurance companies; coping with an uncertain future.

Within the realm of AIDS, there are considered to be three stages of HIV disease. First is HIV positive, no symptoms. Second is symptomatic -- sometimes referred to as ARC. The third stage is an AIDS diagnosis which is based on the Centers for Disease Control's list of qualifying infections.

I was tested for HIV antibodies in March 1986 -- five years ago. My husband, who has hemophilia, tested positive in January 1986. You can't predict how you'd react to a positive test result. Increasingly, we did not freak out. It takes time for the ramifications to set in. It's a painful process.

My husband and I were young, healthy, career-oriented people with an active social life and grandiose plans for the future. HIV did not fit in the picture -- so we went directly into denial. We told no one for over a year.

The issue of disclosure is a recurring theme in many people's experience. For me, personally, the decision not to tell had less to do with fear of isolation or rejection and more to do with not wanting to upset or burden my family and friends. With my co-workers and business associates, I didn't want to be pitied or viewed differently. Also I hated being "labeled." I resented falling into some nebulous statistical category based on "risk groups." To me, AIDS is AIDS regardless of mode of transmission. I believe that this preoccupation with neat little compartments in which to place people hampers our understanding of how this disease affects people's lives. People are dismissed if they fall into certain categories, ("Oh, he's gay," or "he's a drug user") or pitied as "innocent victims" if through blood transfusions or perinatally. There is still a lot of stigma attached to HIV which prevents people from (1) getting tested, (2) getting treatment, and (3) disclosing HIV status.

During the time I was asymptomatic, I was very anxious about my body. Eventually, in 1987 I began having minor dermatological and gynecological problems. I was open with my health care providers about HIV and all reacted well -- no one kicked me out of their office! But my dermatologist couldn't say whether my folliculitis, skin rashes, or warts were HIV-related or not. My gynecologist couldn't say whether my increased vaginal yeast infections were HIV-related or not.

Although I'd yet to seek out HIV-specific doctors, I'd been having my T-cells monitored by the study I'd been enrolled in. They began to drop in early 1988. I began to be seen at UCSF's AIDS Clinic. In May 1988, I began exhibiting classic signs of pneumocystis carinii pneumonia (PCP); coughing, fever, shortness of breath. PCP was confirmed and I now had an official AIDS diagnosis. I was treated with antibiotics on an outpatient basis and within a week was back at work.

Dealing with our situation caused a lot of strain on our relationship. My husband had developed very personal, deeply ingrained coping strategies over many years of living with a chronic illness -- hemophilia. His view of this was, "just one more hurdle to overcome -- no problem!" I, on the other hand, had been very healthy. This was all new to me! Pre-HIV we had a wonderful physical relationship -- a very loving and satisfying part of our lives. After testing positive things changed for me. Sex seemed dirty and I blamed it on HIV. I couldn't enjoy it and my husband felt he was "imposing on me." It took years to reclaim sex as a part of life we deserved to have and enjoy.

We were originally counseled to use condoms (even though we were both positive) and not to become pregnant. Which leads me to the most significant adjustment of all -- realizing we'd never become parents. After our HIV tests, we were counseled that not only could our child be infected, but pregnancy could have a negative effect on my immune system. Being optimists, we began discussing adoption. Eventually I came to accept that we wouldn't have children -- he took longer. This caused a great deal of stress, frustration and arguments between us.

In March 1988, I was asked to co-facilitate a workshop on Loss and Grief at a Hemophilia Educational Symposium. The other facilitator was a psychologist and I realized that loss isn't always about death. I came to realize that I was grieving for someone I'd never know -- my future child. This new outlook helped me work through and cope with this issue.

In October 1989, I had my second bout with PCP. It was my first AIDS-related hospitalization. I was very sick and the drugs were very strong and toxic. By now we were fairly open with friends and family, but not at work.

For me and many others with HIV, the goal is to keep working. Working lends a sense of normalcy to life -- a feeling of productivity. I wondered, "What would I do if I stopped working?" I was in advertising in a high stress, very social job. It involved lots of travel and business functions. When I had my first bout with PCP I told my boss. Although she was personally very sensitive and concerned, I got the distinct impression that I'd blown my chance for advancement. I felt stuck: "I'll never get ahead and I can't leave." I had to redefine my career goals. I had a REAL BAD ATTITUDE for about a year! I had other reasons not to tell people at work: fear that ignorance around transmission issues might come up, financial and insurance concerns, and breach of my husband's confidentiality.

The decision to stop working came in April 1990. I'd returned to work after my bout with PCP. All my energy was going into the Monday through Friday 9 to 5 routine. I finally realized that it was more important to stay healthy and avoid stress. It was becoming clear to my co-workers that something was seriously wrong with me. I consulted with the benefits manager and felt comfortable that financially I'd be OK, so on May 1, 1990, I stopped working. In July I returned to give a talk to my former co-workers, which was beneficial to all of us. (That squelched the cancer rumor that was going around.) How am I doing currently?

Physically, I'm very run down. I suffer from anemia and have had two blood transfusions this year. I miss my health. I miss my independence. I've become unreliable, which I hate.

Psychologically, I am very anxious about my health. How long before the next infection, the next major illness? Should I be taking a different approach to my health care? Am I doing enough? Too much? I miss my sexuality, my sense of being and feeling attractive.

Emotionally, I'm on a roller coaster. I go from feeling anger and resentment, to depression, to feeling joy and amazement over having such wonderful people in my life. My relationship with my husband has never been better. We are very close.

Basically, I have good days and I have bad days. Some days I'm ready to say, "Enough already...I can't live this way anymore." Other days I say "WOW! I'm still here and ain't life great!" Some days I feel totally alone, then I go to a support group or talk to a friend and feel not so alone.

I have some thoughts on Education and Prevention...

First, regarding the language of AIDS. Some of you may remember a campaign a few years ago by people with AIDS to stop the media (and others) from referring to us as "victims." We preferred: People With AIDS (PWAs), or People Living With (as opposed to dying of) AIDS (PLWA). To some this may seem trivial, but in the midst of so much negativity, this adjustment can be very empowering to those of us involved. Currently there is a push to stop referring to AIDS as a fatal disease or terminal illness and move in the direction of a "chronic manageable illness which can be life threatening." We don't want to downplay the seriousness of AIDS, but there has to be some hope offered to those who have been diagnosed.

What is needed is a strong commitment on behalf of political and religious leaders, educators, health providers, the government, the media, and anyone else who influences public opinion to reverse the trend of AIDS-related fear, stigma and discrimination toward a more compassionate and supportive society. "Kinder and gentler"...where have I heard this before?

I'm concerned about lack of complete and frank discussion of condom use as a way to curb the spread of the virus. We seem to be doing the job halfway. There's a glaring absence of condom advertising on television, condom use in love scenes in movies on TV, even an absence of proper use of condoms in HIV literature!

I'm a firm believer that education is our strongest weapon in not only preventing the spread of the virus, but in eliminating fear.

Thank you.

FDA Orders Firm to Stop Selling AIDS Saliva Test

WASHINGTON -- (UPI) The Food and Drug Administration ordered an Oregon company to stop selling insurance companies an unproven, unapproved saliva test for AIDS.

The FDA sent a letter to Epitope Inc. of Beaverton, Ore., ordering the company to stop distributing its OraSure test.

The company also was ordered to retrieve any tests that had been distributed and was told to instruct any companies that received the test kits not to use them.

Epitope did not have any immediate comment.

But Epitope sent a letter to the FDA explaining that the company had "commercially distributed the unapproved device based on its belief" that tests used exclusively by insurance companies would not be regulated by the FDA, Bozzo said.

"Your conclusion that the OraSure specimen collection device when used in testing for (AIDS) by the insurance industry is not a device subject to (premarket approval) is incorrect," he said.

"The commercial distribution of the OraSure specimen collection device for use in testing for (AIDS antibodies) requires (FDA approval)," he said.

The FDA's action followed an investigation by the federal agency prompted by an inquiry by United Press International in April about the use of the test by insurance companies.

Home Office Reference Laboratory Inc. of Kansas City, which has marketed the test, had told UPI that three or four insurance companies had started using the test.

Although saliva does not contain the human immunodeficiency virus it has been found to contain disease-fighting proteins called antibodies that the body produces within two weeks of infection with HIV.

While AIDS tests based on saliva are being tested, the FDA has not approved any AIDS tests other than those involving tests on blood or blood products, noted Thomas Bozzo, director of the FDA's Center for Biologies Evaluation and Research.

Bozzo said the FDA conducted inspections that "documented your firm had manufactured, commercialized, and distributed OraSure collection devices for use by insurance companies to test for antibodies" to the AIDS virus.

"These products are in violation of FDA regulations," he said, because the product had not been shown to be effective or approved by the FDA.

-- The Sentinel

Monopoly Breaker

The Burroughs Wellcome Company has long held a monopoly on AZT and the government thinks it has been long enough. If other drug companies got into the act, the reasoning goes, the resulting competition might reduce the price of the drug. That is why Dr. Bernadine Healy, newly appointed director of the NIH, which contributed to the development of AZT, wants the institute to be named co-inventor of the drug. There is no argument regarding the input of NIH scientists, but there is disagreement about patent law. Burroughs Wellcome says it was granted a use patent in 1988 because its scientists were the first to conceive the idea of using AZT to treat AIDS. The battle now shifts from the laboratory to the courtroom.

The First 100,000 AIDS Deaths

By the end of 1990, almost 10 years after the first AIDS-related death became known to the Centers for Disease Control, more than 100,000 Americans had died as a result of AIDS and human immunodeficiency virus (HIV) infection; about one-third of these deaths occurred in 1990 alone.[1] Overall, 90 percent of all AIDS-related deaths so far have occurred among men. Fifty-nine percent of all AIDS-related deaths have been among homosexual or bisexual men who were not intravenous drug users, while 28 percent have been among users of intravenous drugs. Among the latter, 21 percent were women and heterosexual men and seven percent were homosexual and bisexual men. Of all deaths, 55 percent have been among white non-Hispanics. Seventy-three percent of deaths have been among 25- to 44-year olds, almost equally divided between 25- to 34-year-olds and 35- to 44-year-olds. It is estimated that 165,000 to 215,000 more Americans will have died of HIV-related causes by 1993.

1. "Mortality Attributable to HIV Infection/AIDS -- United States, 1981-1990," *Morbidity ad Mortality Weekly Report*, 40-41, 1991.

Employee AIDS Tests Not Cost Effective

WASHINGTON -- (UPI) Even if it were legal, it would not be cost-effective for most U.S. companies to test employees and prospective employees for the AIDS virus to be able to not hire or fire those infected.

David Bloom ad Sherry Glied of Columbia University in New York analyzed the economics of companies testing employees for the human immunodeficiency virus.

"A fundamental premise of the ensuing analysis is that a firm will test its employees for HIV infection when the firm's expected benefits of testing outweigh its expected costs," they wrote in the journal *Science.*

Businesses might be tempted to screen all potential employees for the AIDS virus to avoid the expense, such as medical costs, of employing such individuals.

"It may seem callous, or irrelevant, to think of HIV testing as an economic issue," they said. "However, a failure to recognize the likely response of the labor market to the epidemic and to HIV testing will not make that response disappear."

The researchers estimated that the cost of identifying someone who is truly infected with HIV would range from $500 to $310,000 but "very few firms are likely to face testing costs at the lower end of this range."

The costs tend to be high because the virus is relatively uncommon in the general working population and therefore many people have to undergo testing to find one truly infected person, the researchers said.

In contrast, the expected benefit of identifying such individuals would be $2,300 to $31,800, "far below the expected cost of identifying a sero-positive individual," they said.

"Thus, most profit-maximizing employers are not likely to find HIV testing to be cost-beneficial personnel policy, even if they are permitted to use test results in making employment decisions," they wrote.

The only firms that might benefit economically would be large firms in cities where the virus is common and offer very good, and therefore expensive, fringe benefits, they said.

In about two-thirds of states it is illegal for an employer to not hire someone or to fire someone because they are infected with the AIDS virus.

-- The Sentinel

Diagnosing Pulmonary Aspergillosis

Pulmonary aspergillosis is a rare, late complication of AIDS. These authors describe a series of 13 cases collected over the past year. Two patterns of disease were noted: invasive disease (10 patients) and obstructing bronchial aspergillosis (three patients). Predisposing factors included steroid use, neutropenia, and use of broad-spectrum antibiotics. The mean time from onset of symptoms to diagnosis of 1.3 months underscores the difficulty in establishing the diagnosis. Transthoracic aspiration may be useful if cavitary or pleural-based lesions are present. The response to treatment with amphotericin and/or itraconazole was variable, but generally poor.

-- AIDS Clinical Care

Genes Called Factor in AIDS Survival

BAR HARBOR, Maine -- (AP) A genetic pattern associated with reduced susceptibility to AIDS has been discovered in men who remain healthy at least five years after being infected, researchers say.

The discovery could improve AIDS treatment by allowing doctors to make better predictions about patients' outcomes, said the leader of the research team, Mary-Claire King of the University of California, Berkeley.

The pattern was found in the HLA genes. These genes are responsible for the rejection of transplanted organs, and help the body fight disease.

"There are some forms of these genes that are relatively protective," King said at a meeting of geneticists at the Jackson Laboratory in Bar Harbor. "Men who have them do better. Those who don't go downhill quickly."

She said there is "tremendous variation in how rapidly the disease progresses."

"This may be very exciting," said Arno Motulsky, a geneticist at the University of Washington in Seattle. Motulsky said studies of genetic susceptibility to AIDS are critically important and have been relatively neglected.

He noted, however, that other genetic factors besides the HLA genes are likely to affect susceptibility to AIDS. "This will not explain all of AIDS," he said.

The genetic pattern found by King, for example, does not explain why some people might be more likely than others to become infected with the AIDS virus. It is related only to patients' outcomes once they have been infected.

King said although she has found genetic "signposts" that point to patients who are less susceptible to the virus, she has not determined precisely which genes are responsible for that reduced susceptibility.

When that is done, researchers might be able to determine exactly how some people are able to partially resist the virus.

-- The Sacramento Bee

California Penal System Planning Nation's First Prison Hospice

by Keith Clark

SAN QUENTIN, Calif. -- With a prison population now just over 100,000 of whom an estimated three percent are believed infected with HIV, California's Department of Correction is in the process of not only enlarging housing facilities for prisoners with AIDS but also of creating the country's first prison hospices for people with the disease.

San Quentin, in Marin County just north of San Francisco, the California Medical Facility at Vacaville, and the state's 19 other prison facilities are all in the process of doubling or tripling the number of HIV beds as the numbers of both prisoners and prisoners with AIDS continues to increase steadily. Since June 1988 the number of HIV-infected inmates in California prisons has tripled from 179 cases to a current level of about 630 cases. And prison officials say that by 1996 they expect there will be more than 2,000 identified cases at the state facilities.

In addition, the state is now designing a pilot program for either San Quentin or the Medical Facility at Vacaville that would create a prison hospice unit at the facility for prisoners with AIDS and other terminal illnesses. The hospice unit would operate at the lowest level of prison security, would be staffed largely by medical, nursing and hospice care workers, and would give ailing inmates far greater and easier access to visitors and contact with one another outside the strict rules and routines of prison life. San Quentin officials have already spent $150,000 renovating a special 20-bed unit in preparation for the program.

The medical staff at San Quentin already works closely with local AIDS agencies, which provide counseling and other assistance to prisoners with the disease. Workers from the agencies also often provide many inmates with the only regular non-prison contacts they have.

"Prisoners have always been looked at in a negative way," said George Mosqueda, director of San Quentin's HIV ward. "This is a great chance for us to network with the community and bring greater outside contacts inside."

Criticism by conservatives that the planned program would "coddle" inmates is flatly dismissed by state prison officials. Dr. Nadim Khoury, chief medical officer for the Department of Corrections, said, "Nonsense. People who are facing a terminal illness like AIDS or cancer can hardly be 'coddled.' It is in fact debatable whether we can even provide the kind of care most people would consider minimal for human dignity."

-- Mom Guess What

Misguided Medical 'Miracles' Make Money for Many

by Sheila R. Enders

You have been given the result -- the HIV test is positive. It means that at some time your body has been exposed to the virus known to result in AIDS. Now what? You search for answers to many questions. You begin an emotional roller coaster. You seek the most current treatments and read everything you can about HIV infection. And, you feel desperate. You will try anything.

Unfortunately, there are people who prey on this type of situation. They purposefully and knowingly offer treatments or therapies promising miracle cures. Faced with the onset of a serious illness, we might all grasp the 'gold ring' approach to care.

Although there are many legitimate studies of investigational drugs carried out under strict guidelines, and alternative therapies we are all aware of, it is essential to be aware of those who will exploit an unhappy situation for their personal benefit and gain. Read between the lines -- are there empty promises? Is the information backed by scientific results? If there are declarations, are they made by legitimate sources?

Before starting self treatments or therapies not ordered by your doctor, be sure to find out as much about the product as possible. Don't be afraid to discuss it with your doctor. He/she may not agree with the treatment, and, in fact, may know something about it you don't know. In any case, it would be important information when looking at your total care.

You are already fighting a tremendous physical and emotional battle with HIV. Be alert to unfounded claims and unscrupulous practices. Don't let someone irresponsible and deceitful rob you of your finances or precious time with promises of miracle cures.

Cats With AIDS-Like Virus Could Provide Clues

BOSTON -- (AP) When veterinarian Dr. Donald Delinks tells cat owners that their pets have the feline form of AIDS, he often sees needless panic.

"Some people say, "But my cat licked me and bit me! Does that mean I'm going to get AIDS?" said Delinks.

The answer is no -- there is no connections between feline immunodeficiency virus, of FIV, and the virus that causes AIDS in humans, scientists say.

Still, experts say the disease could help provide clues to the human virus.

"The viruses are not so similar that the same vaccine that can be used in cats can also be used in humans," said Dr. Neils C. Pedersen, a physician and veterinarian at the University of California at Davis. "But if the human research shows there is a regimen that can be used in man, it might also work well in cats, and visa versa."

FIV has characteristics similar to the AIDS virus, Pedersen said. But experts say FIV cannot be passed to humans and cats cannot develop human AIDS. And veterinarians are shying away from calling the virus "cat AIDS."

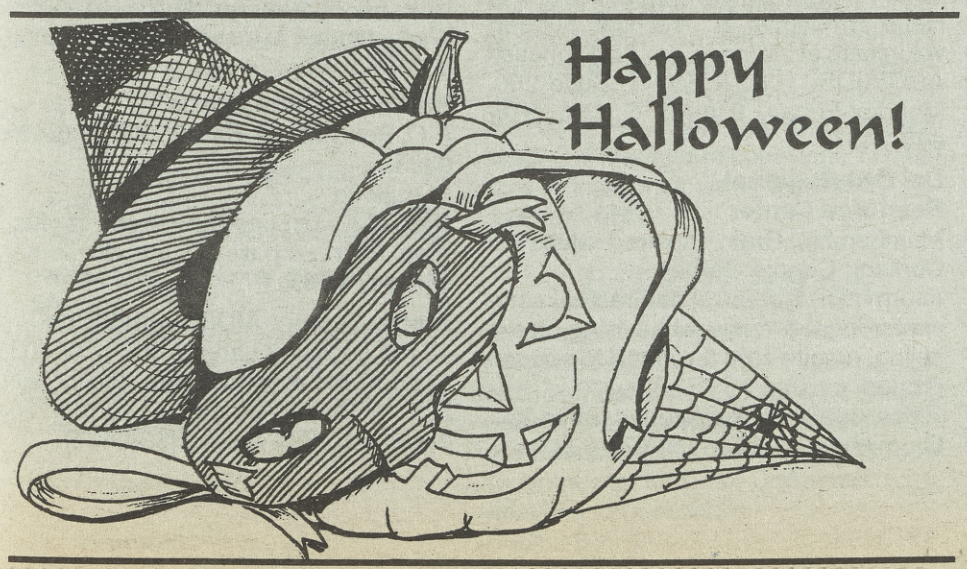
Pedersen is credited with discovering FIV in 1987 by modifying the AIDS test for a chronically ill cat. The cat is the only house pet known to have such a disease.

A woman with a cat shelter saw that other cats in contact with the sick cat also became ill, Pedersen said. The woman suspecting the cat had AIDS, brought it to Pedersen, who was doing research on the human variety of the disease.

UC Davis is sponsoring the first international FIV conference in September.

FIV is transmitted by bites, and it is also believed that an infected female can pass it to her kittens. There is no proof that cats exchange the virus through sex.

-- The Sentinel



State AIDS Issues Are Heading for "The Sticks"

by M.R. Richards

SACRAMENTO -- A bill which has already passed the Senate and heard in Assembly Health Committee on July 9 has some AIDS providers very concerned. Senate Bill 1070 authored by Senator Mike Thompson (D-Napa) would require the Department of Health Services to establish consortia in the state for AIDS case management by 1993. While apparently well-intentioned, the bill has created some concern among AIDS providers about lines of authority in consortia. They are concerned about additional powers being given to county health officers rather than to the actual provider agencies.

A spokesperson in Thompson's office said the bill was motivated by concerns in rural counties about coordination of services such as nursing, social services and homemaker care for HIV and AIDS patients. "In the past three to five years there has been an increase of HIV disease and AIDS in rural counties, said Thompson chief of staff Ed Matovcik, "and we need to provide a responsible level of AIDS services in those rural areas. AIDS doesn't stop at city boundaries and we need to create better conditions in rural areas."

According to one source there is a possibility that some of the bill's wording will be amended to eliminate the terms 'consortia' and 'case management' and will perhaps be limited to rural counties in Northern California. However, the source indicated that any authority engendered by the bill would probably be wielded by county health officials.

-- Mom Guess What

RESOURCE

Support Groups

Antibody Positive Support Group
Membership: People who are HIV+, have ARC or AIDS, male & female, straight & gay.
Contact: Donna Robertson 916/448-2437
Fee: None
Time: 1st & 3rd Wed., 7:30-9 p.m.
Place: Sierra II, 2791 24th St.
Purpose: Emotional Support

Dealing with Loss & Grief
Lecture/discussion by Mark Robinson
Registration: 973-6833
Time: July 22 2-4 p.m.; July 23 6-8 p.m.; Sept. 26 6-8 p.m.; Nov. 26 6-8 p.m.
Place: Kaiser Hospital

HIV+ Emotional Support Group
Facilitators: John Linder, Will Green
Place: Buhler Building, 2800 L Street, classroom #1
Time: 1st & 3rd Wed.

The Positive Group
Membership: HIV+ substance abusers & their significant others.
Contact: Brian or Joel, The Effort, 916/444-6294
Fee: none
Time: Thurs., 1:30-3:30 p.m.
Place: 1820 J Street
Purpose: Education & emotional support

AIDS/ARC/HIV+ North Hall AA Group
Open to everyone with a desire to stop drinking.
Time: Sun., 4 p.m.
Place: MCC, 2741 34th Street near Broadway

Brother to Brother
Membership: Gay African-American HIV+ mens support group. Dealing with HIV, ARC or AIDS? Tired of not being counted?
Contact: Joe Hawkins, Project Survival, 916/454-0516
Fee: none
Time: Mon., 7 p.m.
Place: Call for location
Purpose: Emotional & social support. Strictly confidential

Grupo Para Latinos
Infectados y afectados con la virus HIV, Latinos de Habla Hispana o Bilingues-Facilitado por Patricia Osuna, LCSW.
Contact: 916/448-2437
Fee: none
Tiempo a las 6 p.m.
Lugan: SAF, 1900 K Street, #200

MCC People Together
Membership: People who are HIV+, ARC or AIDS, or other catastrophic illnesses & those who love & support.
Contact: Sandy or PJ, 916/454-4762.
Fee: none
Time: Tues., 7:30-9 p.m.
Place: RCMCC Activity Center, 2741 34th Street
Purpose: Social & spiritual support group sponsored by the River City Metropolitan Community Church. Everyone Welcome.

Woman to Woman
Membership: women of color who are HIV+, ARC or AIDS. Child care & transportation available.
Contact: Betty Baker, Project Survival, 916/454-0516
Fee: none
Time: Mon., 5-7 p.m.
Place: 3501 Broadway
Purpose: Emotional & social support.

Women's Support Group
Membership: HIV+ women
Contact: Donna Robertson, Sacramento AIDS Foundation, 916/448-2437.
Fee: none
Time: Tues., 6:30-8:30 p.m.
Place: SAF, 1900 K Street, 2nd floor
Purpose: Education & emotional support.

Let's Talk Peer Group (Queers with Fears)
Membership: Gay/bisexual men only
time: 2nd & 4th Wed., 7-8:30 p.m.
Fee: none
Place: CARES Clinic, 2710 Capitol Avenue

Women's Support Group
Purpose: One on one counseling for HIV+ women
Contact: Judi Marcelle, Mercy General Hospital Social Services, 916/453-4589.
Free: free
Place: 4001 J Street

Support Groups for Partners, Family & Friends

HIV-AIDS Family Support Group
Membership: Parents & adult siblings, among the HIV/AIDS spectrum: diagnosis through bereavement.
Contact: Pastor Todd VanLaningham, 916/483-5691 or 916/456-9642.
Fee: none
time: 7-8:30 p.m.
Place: Lutheran Church of Our Redeemer, 4641 Marconi Ave. at Mission
Purpose: Emotional support

Hemophiliac Support Groups
Male Support Group
Membership: Hemophiliac & blood transfusion men with HIV.
Contact: Vicki Burdur, Bi-Valley Medical Clinic, 916/442-4985.
Fee: none
Time: Every Tues., 9 a.m.
Place: 2100 Capitol Avenue
Purpose: Education & emotional support

Parents Support Group
Membership: Parents of adults & children with hemophilia
Fee: none
time: 3rd Thurs., 7-8:30 p.m.
Place: 2100 Capitol Ave.
Purpose: Education & emotional support

For Mothers Only
Membership: Mother's Peer support Group
Contact: Peggy Zarembo, 916/447-5075
Fee: none
Time: Tues., 1:30 p.m. at SAF
Purpose: Support for mothers of people with HIV, ARC & AIDS & mothers who have lost sons & daughters to AIDS.

Spiritual Groups

SUFI Healing ARTs (MTO)
Membership: People who are HIV+, ARC or AIDS.
Contact: Linda O'Riordan, R.M., 916/487-0323.
Fee: Donation requested.
Time/Place: Call for current time & location.
Purpose: SUFI healing, concentration & medicationation classes.

Healing Circle
Time: 7:30-9 p.m. Fridays
Fee: Love offering
Contact: Michael Queen 441-6645

Life Celebration
Time: 8 p.m. Wednesdays
Place: Star Temple (K Street, between 27th & 28th)
Fee: Love offering
Contact: Michael Queen 441-6645

Suicide Prevention
Volunteers available 24 hours to help individuals through times of crisis. TTD capabilities for the hearing impaired.
Emergency: 916/368-3111, office: 916/368-3118.

Transformational Energetics
Workshops ton transofrmation & healing primarily focused on deep healing issues for people with HIV & other life-threatening illnesses.
Contact: Michael Dulling, MD, 916/422-1234
Fee: negotiable

Support Services

Sacramento AIDS Foundation
Provides AIDS Education, client service, community outreach & maintains a Volunteers Speakers Bureau. Hand to Hand Emotional & Practical Support volunteers available to clients diagnosed ARC/AIDS. 1900 K Street, Suite 200, Monday-Friday, 9 a.m. -5 p.m., 916/448-2437.

Del Oro Regional Resource Center
Membership: Brain impaired adults
Contact: Connie Gerber
Information & referral contractual service for legal & financial advising, counseling, respite care & referral to support groups.
Place: 3625 Mission Avenue, Suite 300, Carmichael, 95608, 916/971-0893.

CARES Clinic
Provide counseling, early intervention/medical attention to HIV+ individuals. 2710 Capitol Avenue, Mon.-Fri., 9 a.m.-5 p.m., 916/443-3299. Fee for service.

AIDS Survivors of Nevada County, Inc. (ASNC)
Membership: All HIV+ persons in Western Nevada County, since 1989.
Support group meets every Tues., 7 p.m.; caregiver referral, HIV resource library, speakers bureau, social events. Professional facilitated. 916/265-2199.

Lambda Community Center
Information & resources to help the individual with HIV. 1931 L Street, Mon.-Friday, 10 a.m.-6 p.m. 916/442-0185; info line: 916/447-5755.

Being Alive "Living Room"
Drop-in social time for people living with HIV at the Lambda Community Center every Thurs. from 2-5 p.m. 1931 L Street, for more info call 916/442-0185.

Sierra AIDS Council
Support services for people dealing with HIV disease in Amador, Calaveras & Tuolumne Counties
P.O. Box 1062, Sonora, 95370
209/533-2873

W.C.I.C. (Women's Civic Improvement Club) Project Survival
Minority issues & AIDS, 3501 Broadway, 916/454-0516.
Contact: Nadine L. Roberts or Joe Hawkins

The Effort
IVDU treatment program, AIDS education, counseling & confidential testing. 1820 J Street, 916/444-6294.

Hospice Care of Sacramento, Inc.
Providing services to persons coping with a terminal illness & their families. 2007 O Street, Suite 100, 916/443-0398.
Fee: none

Planned Parenthood of Sacramento Valley
AIDS Education to youth detention, homeless shelters & classrooms. 1507 21st Street, Suite 301-A, 916/446-0930.
Fee: none

Alcoholics Anonymous
2425 Alhambra Blvd., Sac., 916/454-1100.
Gay AA Group, "Trust the Process," Wed., noon-1 p.m. at Lambda Center, 916/442-0185.

Narcotics Anonymous
P.O. Box 162416, Sac. 95816, 916/486-0465.
Fee: none
Gay N.A. Group, "Lavender Nights," Mon. & Fri., 8 p.m. at Lambda Center, 916/442-0185.

Placer County AIDS Foundation
12183 Locksley Lane, Auburn, 95603
Support services for those dealing with HIV in Placer County & surrounding areas. 916/889-AIDS (889-2437).

G U I D E

Legal

Sacramento AIDS Legal Referral Panel
Contact: June Black or Ellen Juarez, 916/444-6760.
Fee: Reasonable or no fees for AIDS-related matters.
Place: 515 12th Street
(Must state that you were referred by the Sacramento AIDS Foundation).

Medical Clinics

AIDS Related Disorders Clinic (ARDC)
University of California, Davis, Medical Center, Primary Care Building
Provides medical care to people with HIV disease.
2315 Stockton Blvd., Sacramento, 916/734-7194.

AIDS Research Office
UCDMC, 916/734-8282

CARES
Provide medical evaluation, personal counseling, health education & referrals for HIV positive people.
Fee for service
2710 Capitol Avenue, Sacramento, 916/443-3299.

HIV Clinic
Offers medical care for individuals who need a general work-up related to HIV infection.
Fee: none
1500 C Street, Sacramento, 916/440-5302

Infectious Disease Unit
University of California, Davis, Medical Center, 916/734-3741

County AZT Program
No AZT free.
2921 Stockton Blvd., Sacramento, 916/732-3770.

HIV Antibody Testing

Capitol Health Center
1500 C Street
Call for information & appointments for free, anonymous test on Wed./Thurs., 4:30-5 p.m., 916/440-7720.

The Effort
1820 J Street
Call for information & appointment for free, anonymous test on Tues. & Thurs. evenings, 916/446-6467, call after 3 p.m.

Chemical Dependency Center for Women
1507 21st Street. HIV testing for Intravenous drug users & their partners. Confidential testing Thurs., 3:30-5:30 p.m., 916/448-2951.

Hispanic AIDS Community Educational Resources
7000 Franklin Blvd., Suite 210. HIV anti-body testing with bilingual counselors available Tues. evenings from 5-7 p.m. 916/392-7815 or 916/734-8282.

Political

Lobby for Individual Freedom & Equality (LIFE)
Statewide AIDS lobbying group representing 70 gay, lesbian & AIDS organizations
926 J Street, Suite 1020, 916/444-0424

Lambda Letters Project
Organizes letter writing campaigns expressing community opinions on women's issues, gay & lesbian rights & AIDS issues. The group also offers letter writing assistance to people who would like to express their viewpoints.
916/965-6851

AIDS Action League
Offers housing assistance to people with AIDS. Organizes projects which directly benefit people with AIDS & provides educational information.
Fee: negotiable
2612 J Street, Suite 6, Sacramento, 916/448-4027.

Food

A Touch of Sabbatt
A monthly delivery of homemade chicken soup & challah (bread) the last Friday of each month for people with AIDS or ARC. for more information call 916/921-1313 or 916/482-1432.
Free food closets

Products

Sunergy - Herb Food Concentrates
Sunrider nutritional products & philosophy formulated after the ancient Chinese tradition of nourishing the body with whole foods & the proper combination of herb foods.
Local distributor: Gina Milbourn, 916/991-0860

Reliable Medical Resources
Quality Health care roducts ranging from personal aids/support equipment, incontinency protections & skin care products. Available at no cost to individuals with Medi-Cal/Medi-Care coverage. Lowest cost to insurance plans & private pay.
916/383-6868.

Information

Project Inform
Non-profit information resource group & hotline for alternative & experimental treatment updates including Compound Q, alpha interferon, AZT, aloe vera juice, ribavirin, DNCB, etc.
Hotline 800/822-7422 or 415/928-0293.

AIDS Treatment News
Bi-weekly publication that covers up-to-date issues on alternative & holistic therapies. Subscription charge with a reduced rate for people with HIV. Write John James, P.O. Box 411256, San Francisco, CA 94141.

National AIDS Information Clearing House
Local & national computerized resource listings & informational publications, many available free of charge to people with HIV such as the AMFAR (American Foundation for AIDS Research) Directory of Experimental Treatments.
800/458-5231 or 212/719-0033.

BETA (Bulletin of Experimental Treatments for AIDS)
Publication of the San Francisco AIDs Foundation. Educational resource for people reviewing experimental treatments for HIV. Free to San Francisco residents, subscription charge for others.
800/FOR-AIDS for sample copy & information.

NIH (National Institute of Health)
Drug Trials Information
toll-free phone line with information on federally funded clinical trials researching AIDS treatments with information provided by APA MONITOR (American Psychological Association).
800/TRIALS-A or 800/874-2572

AIDS Library of Philadelphia
32 N. Third Street, Philadelphia, PA 19106, 215/922-5120

Northern California AIDS Hotline
800/367-2437

AIDS Drug Hotline
800/334-7422

UC Davis Medical Library (MED-LINE)
916/453-3529

Persons with AIDS (PWA) Hotline
800/367-2437 or 415/861-7309

National Association of People with AIDS
2025 Eye Street, NW, Suite 415, Washington, D.C., 20006
202/2856

Mothers of AIDS Patients
P.O. Box 89049, San Diego, CA 92138
619/426-1317

Teen AIDS Hotline
800/234-TEEN
National Library of Medicine (for subject searches, AIDS LINE 301/496-6095

The NAMES Project
Educating the world by remembering those who have died of AIDS by creating memorial quilt panels with love.
2362 Market Street, San Francisco, 415/863-5511.

California State University, Sacramento, Health Center
6000 J Street. HIV info line 916/278-6461.

Religious Services

River City Metropolitan Community Church
2741 34th Street, 916/454-4762
Sunday Worship Services: 9 a.m., 11 a.m. & 6 p.m., Sunday School during 11 a.m. worship for Children 2-2.
TV ministry on Channel 17, 7 p.m.

Newspapers

Available at Lambda Community Center

the latest ISSUE
Sacramento's news magazine for the gay community and its friends
P.O. Box 160584, Sacramento 95816
916/737-1088

MGW Newspaper
First & oldest newspaper for the gay community
1725 L Street, Sacramento 95814
916/441-NEWS

Patlar
"Voice of Gay America"
P.O. Box 22402, Sacramento
916/452-0769

BLK
Blk Publishing Company
P.O. Box 83912, Los Angeles, CA 90038-0912

The Sentinel
California's statewide gay newsweekly.
415/861-8431 for subscription information.

Bay Area Reporter (BAR)
Excellent information & news source.
395 Ninth Street, San Francisco, CA 94103.
Available at Tower Books or by subscription, 415/861-5019 for information.

Workshops

The MENS Session
We all know we need to have safe sex, but maintaining changes in how we have sex can be very difficult.
The MENS Session hels men adjust to those changes in a fun, sex-positive & information workshop.
Fee: none
Call Sacramento AIDS Foundation for dates & times, 916/448-2437.

Lambda U
An ongoing series of workshops on a wide variety of subjects.
Fee: none
Place: Lambda Community Center, 1931 L Street, 95814
Information: 916/442-0185

AIDS is Changing Sex Habits

Half of American adults who are single and younger than 45 say they have changed their sexual behavior because of fear of getting AIDS, according to the latest *New York Times/CBS News Poll.*

The poll also found signs of increased acquaintance with people with of AIDS and of heightened public knowledge about AIDS during the past six years.

In the survey, 21 percent of Americans adults said they either knew someone who has AIDS or knew someone who had already died from AIDS.

When the *Times* and *CBS News* first polled about acquaintances with people with AIDS in 1985, only two percent said they knew someone with acquired immune deficiency syndrome.

Forty percent of all adults now profess to "know a lot" about AIDS. That is an increase from 11 percent who described themselves as knowing a lot in the 1985 poll.

An additional four of 10 respondents in each of the polls said they had some knowledge about AIDS.

When asked whether they had changed their sexual behavior because of fear of getting AIDS, 20 percent of all adults nationwide now say they have.

That is up from 11 percent measured in a *CBS News Poll* taken in 1986, but about the same as the 19 percent in a 1989 *CBS News Poll.*

Several subgroups in the new poll reported changes in behavior at rates sharply higher than the overall level: 43 percent of single adults, 40 percent of those 18 to 29 years, 38 percent of blacks, 35 percent of big-city residents, and 32 percent of Hispanic respondents said they had changed their sexual behavior to reduce their chances of getting AIDS.

When single adults younger than 45 were analyzed, 52 percent said they had changed their sexual behavior to avoid AIDS.

When pressed to say what changes they made, respondents most frequently cited using condoms and limiting the number of sexual partners.

-- New York Times

AFFIRMATION

I LOVE & APPROVE OF MYSELF. I CREATE MY OWN JOY & CHOOSE TO BE A WINNER IN LIFE.

Senate's Jail Threat for Silence on AIDS

by Lawrence M. O'Rourke

WASHINGTON -- The Senate has approved a proposal to send health-care workers with the AIDS virus to prison for at least 10 years if they fail to disclose their infection to patients before performing high-risk treatments.

The proposal by Sen. Jesse Helms, R-N.C., passed 81-18 after Helms recalled the story of Kimberly Bergalis, 23, of Fort Pierce, Fla., who was infected by a dentist with AIDS, as were four other patients.

"She doesn't have a chance," Helms said of Bergalis, who is dying of the disease. "So I don't think a 10-year sentence is severe when you talk about what these people are willing to do to their innocent patients."

The Senate also approved a measure endorsed by the Bush administration and both Democratic and Republican Senate leaders that would virtually require all doctors, dentists and nurses who perform high-risk treatments to be tested for the AIDS virus.

The measures now go to the House, where a bill introduced by Rep. William Dannemeyer, R-Fullerton, would require regular testing of health-care workers and some patients.

The Helms proposal calls for a 10-year prison term, a fine of up to $10,000, or both for a health-care worker infected with the HIV virus, which causes AIDS, who has "invasive physical contact" with a patient without first disclosing the caregiver's infection.

The punishments under Helms' proposal would not apply to HIV-positive medial personnel who deal with an emergency case "in which alternative medical treatment is not reasonably available."

The measure's passage "was a triumph of hysteria over science," said Howard L. Lang, president of the California Medical Association. Lang argued that the HIV risk to a patient from a health-care worker is "so small as to be statistically unmeasurable."

Sen. John Seymour, R-Calif., voted in favor of Helms' proposal, Sen. Alan Cranston, D-Calif., voted against it.

Sen. David Durenberger, R-Minn. asked if "any of these people who already have a fatal disease are going to be deterred by a prison sentence." He added, "We need prevention, not punishment. We need to cure AIDS, not criminalize it."

The Senate also approved a measure by a 99-0 vote to compel states to follow AIDS guidelines adopted by the federal Centers for Disease Control for health-care professionals.

The CDC guidelines said physicians, dentists and other health-care workers who perform exposure-prone procedures should find out their HIV and hepatitis B status.

"Any who are infected with HIV or the most virulent form of hepatitis B should not carry out procedures unless they have obtained permission and guidance from special review committees, which will require, at minimum, that potential patients be informed of the workers' HIV or hepatitis B status," the CDC said.

Louis W. Sullivan, secretary of health and human services, said as he announced the guidelines that "patients deserve accurate information and they deserve the best measures to protect them from disease transmission."

Assistance Secretary for Health James D. Mason said, "We must get across to the public that in most medical situations there's no more risk from a potentially HIV-infected nurse or doctor than from a lawyer, cab driver or teacher."

The guidelines require sterilization of equipment and careful handling and disposal of hypodermic needles and other sharp instruments. They also state that "gloves should be worn by all health practitioners while performing invasive procedures and whenever they come in contact with blood or body fluids."

Under the provision adopted by the Senate, health-care personnel who violate the guidelines would risk discipline by state licensing boards.

The Senate would require states to adopt the CDC guidelines within a year. Any state that refused would lose Public Health Service grants, which total several hundred million dollars a year.

The American Medical Association and the American Dental Association have recommended that AIDS-infected doctors and dentists stop performing procedures that involve exposure to blood unless patients know of their condition and consent to treatment.

-- The Sacramento Bee

Americans in Poll Favor Broad AIDS Testing

PRINCETON, N.J. -- A substantial majority of Americans surveyed continues to favor AIDS testing for people in a number of at-risk populations.

And in the case of four groups that have been the subject of recent controversy and press coverage, virtually everyone asked backs AIDS testing. Almost nine in 10 questioned support AIDS testing for dentists, doctors and nurses -- and eight in 10 support testing for patients entering hospitals. These results are based on 1,014 interviews conducted by the Gallup Poll.

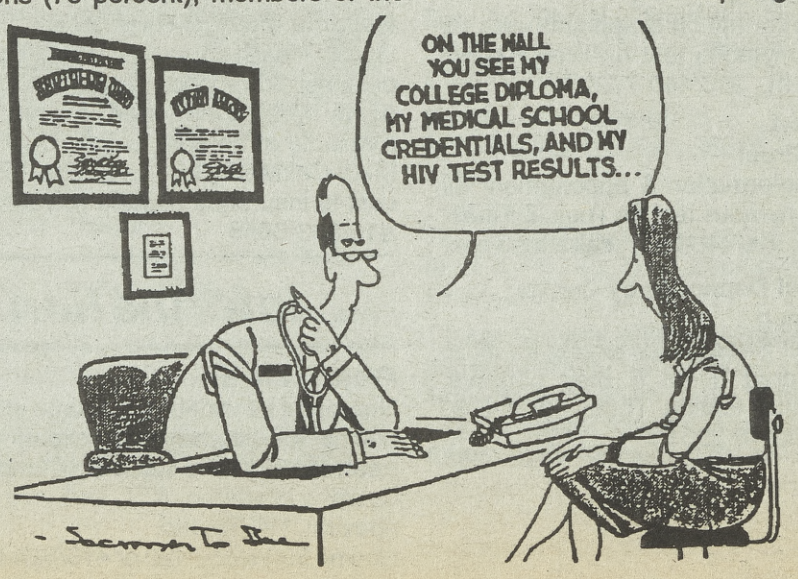
At the same time, comparison of findings between today and 1987 on a number of key measures reveals an increased compassion and tolerance for AIDS victims on the part of Americans. Some of these increases are dramatic. In 1987, for example, a slight majority of Americans (51 percent) surveyed agreed with the statement that it is a person's own fault if he gets AIDS -- today, only one in three agrees.

Despite protests from civil libertarians and gay rights advocates, Americans who were questioned overwhelmingly feel that members of groups in a position to transmit AIDS or at high-risk of having the disease should be tested.

A majority of those questioned continue to favor testing for the following groups: couples applying for marriage licenses(82 percent), immigrants applying for permanent status in the United States (81 percent), inmates of federal prisons (78 percent), members of the armed forces (67 percent) and visitors from foreign countries (62 percent). In fact, about half of those asked (46 percent) think all U.S. citizens should be tested.

On several other measures relating to AIDS, the Gallup Poll suggests that the public is displaying increased sensitivity and compassion for those who have contracted the disease.

-- The Gallup Organization



Immunizations in HIV-Infected Patients

Vaccination of HIV-infected patients differs from vaccination in the general population for several reasons: Persons with HIV infection have an increased risk of acquiring, or developing complications from, several diseases for which vaccines exist; thus these vaccines may be of greater importance in HIV infection. Concerns have been raised, though, that the antigenic stimulation associated with vaccination might accelerate the course of HIV infection. To date, these fears have not been substantiated by vaccination studies, which have found no effect on the clinical course of disease or on laboratory markers of disease activity. However, concern that live attenuated vaccines may pose greater risk in HIV-infected patients have been supported by one report, which describes severe disseminated infection resulting from vaccinia immunization.

Response rates to vaccinations are lower in patients with HIV infection. In several studies, response rates have been shown to decline progressively as patients advance from the asymptomatic stage to AIDS-related complex, and then to AIDS. This suggests that, when possible, vaccines offering long-term protection should be given early in the course of HIV infection to maximize the likelihood of a good response.

Pneumococcal Vaccine: Patients with HIV infection have a markedly increased incidence of pneumococcal pneumonia when compared with the general population. Because of this, the CDC now includes HIV infection as an indication for pneumococcal vaccination.

Although response rates are lower than those in the general population, in one study 88 percent of asymptomatic HIV-infected subjects developed protective antibody titers to at least one component of the 23-valent vaccine, suggesting that most asymptomatic patients will benefit from receiving it.

Hepatitis B Vaccine: HIV-infected persons who become infected with hepatitis B virus (HBV) are reported to have a 19 to 37 percent risk of becoming chronic HBV carriers, compared with a six percent risk in homosexual men without HIV infection. The same risk behaviors that lead to HIV infection also place one at risk of acquiring HBV. Thus, most people with HIV infection fall into groups for which HBV vaccination is recommended. Although vaccination may be unnecessary if all risk behaviors have stopped, it is often difficult to be certain and it is usually preferable to err on the side of caution and vaccinate if there is any question.

Again, although antibody responses are reduced in HIV infection, in one study at least 75 percent of asymptomatic patients achieved the minimum response associated with protection against HBV. Patients who do not respond to the initial course of vaccination are unlikely to respond to a second.

Because HBV vaccine is expensive, and there is high prevalence of past exposure to HBV in most populations with HIV infection, it is usually cost-effective to screen for past HBV exposure prior to vaccination using a hepatitis B surface antigen and antibody, or hepatitis B core antibody. Only persons without evidence of past exposure need vaccination.

Influenza Vaccine: Patients with HIV infection are more vulnerable to the complications of influenza, such as pneumococcal or haemophilus pneumonia. In addition, the symptoms of influenza may arouse concern that an opportunistic infection is present, causing anxiety for the patient and leading to potentially costly diagnostic evaluations.

Measles Vaccine: Measles vaccine is recommended for adults born after 1956. There have been several reports of severe measles in children with HIV infection, and few reports of serious adverse reactions to vaccination. This has led to recommendations that HIV-infected children should receive measles vaccine, even though it is a live vaccine. Whether this recommendation should be extended to HIV-infected adults is uncertain as there is a paucity of information about its safety in these patients. Only three cases have been reported of previously unexposed HIV-infected adults receiving measles vaccination. While none of these persons had adverse reactions, none of them developed immunity either.

Other Vaccines: Diphtheria and tetanus vaccine can be given as in non-HIV-infected persons, and pertussis can be administered as part of an initial immunization series for HIV-infected children. In these patients, and in adults for whom polio immunization is indicated, inactivated rather than live vaccine should be used. Healthy children known to be living with immunosuppressed children or adults should also receive inactivated vaccine to avoid exposing their household members to excreted live virus. Although there are no reports of serious adverse reactions in children receiving rubella vaccine, there is no information on its efficacy or safety in HIV-infected adults.

Vaccination of HIV-Infected Adults

Vaccine	Frequency	Comments
Pneumococcal vaccine	Once	HIV infection predisposes to pneumococcal infections.
Hepatitis B vaccine	Series of 3	Indicated if there is no prior hepatitis B exposure
Influenza vaccine	Yearly	November ("flu season") is the optimal time for maximizing protection.
Haemophilus influenzae vaccine	See comments	Should be considered; efficacy is uncertain.
Eiphtheria & Tetanus	Every 10 years	Administer if a booster is indicated.

These factors provide the rationale for influenza vaccination in HIV-infected persons. In asymptomatic patients, 52 to 89 percent have achieved protective antibody titers with influenza vaccine, compared to 13 to 50 percent of patients with ARC or AIDS.

Haemophilus influenzae Vaccine: The incidence of *Haemophilus influenzae* pneumonia is increased in patients with HIV infection. The CDC recommends that, like other children, children with HIV infection should receive *H. influenzae* type B conjugated vaccine (HbcV). The CDC also suggests that adults with HIV infection should be given the immunizations they did not receive in childhood; this implies that administration of HbcV should be considered, since the vaccine was not available until recently. However, recent CDC recommendations for HbcV state that while its use is not contraindicated in HIV-infected adults, its utility is uncertain.

By adulthood, 95 percent of the population has antibodies to *H. influenzae* type B capsular antigens. While HbcV may increase antibody levels to the capsular antigens, it is not certain that this will provide additional protection. Furthermore, most *H. influenzae* disease in non-HIV-infected adults is not caused by *H. influenzae* type B, the only type against which the vaccine provides protection. While limited data are available about the type of *H. influenzae* causing disease in HIV-infected adults, the data suggest that most strains are not type B.

Frederick M. Hecht, MD, is an attending physician at the Montefiore Medical Center's AIDS Center in the Bronx. Bruce Soloway, MD, is Medical Director of the Bronx-Lebanon Family Practice Center.

-- AIDS Clinical Care

AFFIRMATION

I RELEASE THE PAST & FORGIVE EVERYONE.

d4T: New Drug On the Block

by Dave Gilden

One chemical now making the AIDS treatment scene is Bristol-Myers Squibb Company's d4T. The substance is a nucleoside analog very similar to AZT, but without the conventional drug's nitrogen atoms. Large-scale, second phase trials involving 140 people at seven sites around the country got underway in April. Already, popular anecdote has made d4T a focus for the desperate hope of people dependent on the United States' lumbering drug development system for life-saving medication.

Tales of dramatic improvements while using experimental treatments are not new to the AIDS epidemic. In Providence, Rhode Island, Dr. Kenneth Mayer, who is conducting some of the ongoing d4T trials, thinks, "It is premature to get excited. Not enough people have tried d4T to say how good it really is."

Nonetheless, Mayer's original study group of 20 had a quick boost in helper T-cells and amelioration of major AIDS-related symptoms. "d4T should be on the development fast track," he said.

Like other nucleoside analogs, d4T functions as a defective sub-unit of DNA, the substance that makes up human cells' genes. d4T's sole role is to stop the HIV virus from insinuating itself into those genes. It is active only when the virus is in the cell nucleus, trying to build a DNA copy of its own genetic material.

Should d4T miss that opportunity, the cell is irretrievably infected with HIV. Because of d4T's limited arena for action, it is difficult to see how a nucleoside analog alone could work as a cure or near cure for AIDS. At that stage, millions of infected cells exist, constantly manufacturing new virus particles.

-- Southern Voice

Spontaneous Pneumothorax in AIDS

Spontaneous pneumothorax, a relatively uncommon event in AIDS, is more likely to occur in patients who have a history of past PCP and in those who have received aerosolized pentamidine prophylaxis, according to a 10-year prospective study of 1030 AIDS patients. Seventeen of the 20 patients who developed pneumothorax in this study had both risk factors. Nineteen of the 20 pneumothoraces were accompanied by evidence of active PCP, and most caused severe morbidity. Pneumothorax may result from chronic, subclinical, peripheral, necrotizing pneumocystis pneumonitis beyond reach of aerosolized pentamidine. The authors suggest that any patient with AIDS and spontaneous pneumothorax be treated presumptively for PCP.

-- AIDS Clinical Care

Conference

Continued from page 1

ment," Volberding stated that an important research finding was that the size of the red blood cells in those taking AZT increased by 15 to 20 percent when compared with those on the placebo. The researcher added, "this is a good measure of patients' compliance."

Vaccine Research

In a presentation on vaccines, a researcher predicted that several HIV vaccine models will move into large scale human trials within the next three years. Researchers Dani Bolognesi, director of the Center for AIDS Research at Duke University in North Carolina, reported progress in research aimed at prophylaxis vaccine for the uninfected and immunotherapeutic vaccines for those already exposed to the HIV virus.

Bolognesi noted research gains in assimilating the simian immunodeficiency virus (SIV) monkey model as well as the HIV chimpanzee model and promising results in human clinical trials as encouraging indicators in support of his prediction.

Investigators from Vanderbilt University in Nashville, Tennessee presented data generated from the U.S. vaccine testing units and the Center for AIDS Research laboratories at Duke University substantiating that functional antibodies were elicited by an initial "priming" inoculation with a recombinant vaccine-based gp160 vaccine (Oncogen/Bristol Myers-Squibb) followed by a "booster" inoculation of a gp160 subunit vaccine (Micro Gene Sys). The primer-booster combination according to Bolognesi "is the horse in the lead at the moment."

Researchers are in general agreement as to the beneficial aspects of immunotherapeutic vaccines for individuals exposed to the HIV virus. Presentations at the conference featuring preliminary data indicates that the HIV+ individual immunotherapeutic vaccine models slow the T-helper cell decline and weight loss syndrome and susceptibility to opportunistic infections. Bolognesi commented that immunotherapeutic vaccines "may be tipping the balance in favor of the host." Reflecting on the state of vaccine research, Bolognesi commented "this whole field is bubbling."

Antibiotic Combination for Moderate PCP

Researchers from Indiana University in Indianapolis reported a new combination of antibiotics which were proving to be an effective and relatively non-toxic alternative treatment for mild-to-moderate Pneumocystis Carinii Pneumonia (PCP). Researcher John Black and his colleagues stated that a regime of oral clindamycin with primaquine produced promising results and was well tolerated in clinical trial volunteers. Initial animal studies suggested that clindamycin and primaquine were more effective against PCP when combined than when used alone.

The tabulated results of two studies show that 55 out of 60 patients responded to treatment with 46 (77 percent) completing the trial protocol. Black stated that all but one of the trial participants survived (the one who died had a lung infection in addition to a PCP diagnosis). Six trial participants experienced mild diarrhea with others exhibiting a tolerable skin rash.

Black noted that most patients who begin standard treatments for PCP, pentamidine or trimethoprim/sulfamethoxazole, do not finish the treatment protocols because of toxic side effects. "Our work and that of others who have used this new combination suggests that this is a relatively non-toxic and effective alternative treatment for mild-to-moderate PCP," Black said.

Researchers are currently planning a large Phase 3 double-bind study comparing the combination of clindamycin plus primaquine to determine which of the three oral therapies exhibits the least toxicity.

Cell Infection Sequence Identified

British researchers reported identifying a previously unknown step in the HIV virus sequence of infecting healthy T-helper cells. In findings presented by Thomas Schulz, clinical research scientist at the Institute of Cancer Research in London, the researcher stated that he and his colleagues hypothesize that a naturally occurring enzyme is responsible for enabling the HIV virus to infect health cells.

The researchers noted that while previous research identifying T-helper cells as the target for the HIV virus were significant, left unanswered was the question of how infection actually occurred once the HIV virus bonded to the T-helper cells. The scientists reported that they focused their research efforts on the gp120 envelope protein identified as the V3 loop. The researchers stated that their scientific data indicates that this is the cleavage site where the enzyme splits the gp120 and fuses the envelope's protein membrane with the membrane of the HIV virus. The fusion of the cell membranes allows the HIV cell structure to become integrated with that of the healthy cell.

"If we could find a substance that inhibits this enzyme, it might interfere with virus entry. But there is no indication that such an inhibitor exists that could be used for therapy. If theory holds up, however, that will be another avenue in which to look for a drug," Schulz stated.

Drug Reported to Slow KS progression

Reknowned AIDS researcher, Robert Gallo of the National Cancer Institute reported that a drug known as SP-PG diminished and even prevented KS (Kaposi sarcoma) in animal research experiments. The drug, according to Gallo, caused a "profound inhibition of the growth of Kaposi's sarcoma spindle cells."

Gallo explained that he believes the purple KS lesions, which can be manifested on both the skin and internal organs, originate from blood vessel cells and grow in response to substances released by the HIV virus. Gallo stated that SP-PG inhibits the blood vessel cell growth and may have additional neutralizing properties. "It can literally melt away the tumor, and once treated, the tumor can't grow back," stated Martin Delaney of San Francisco's Project Inform, a patient advocacy group which has been closely following research and availability of the drug.

The drug, made by Dai-Ichi Pharmaceuticals in Japan, is a natural substance produced by a specific type of soil bacteria. If SP-PG is successful in clinical trials, it will be the first treatment specifically designed for KS.

AFFIRMATION

I NOW HAVE ENOUGH TIME, ENERGY, WISDOM AND MONEY TO ACCOMPLISH ALL MY DESIRES.

CDC

continued from page 1

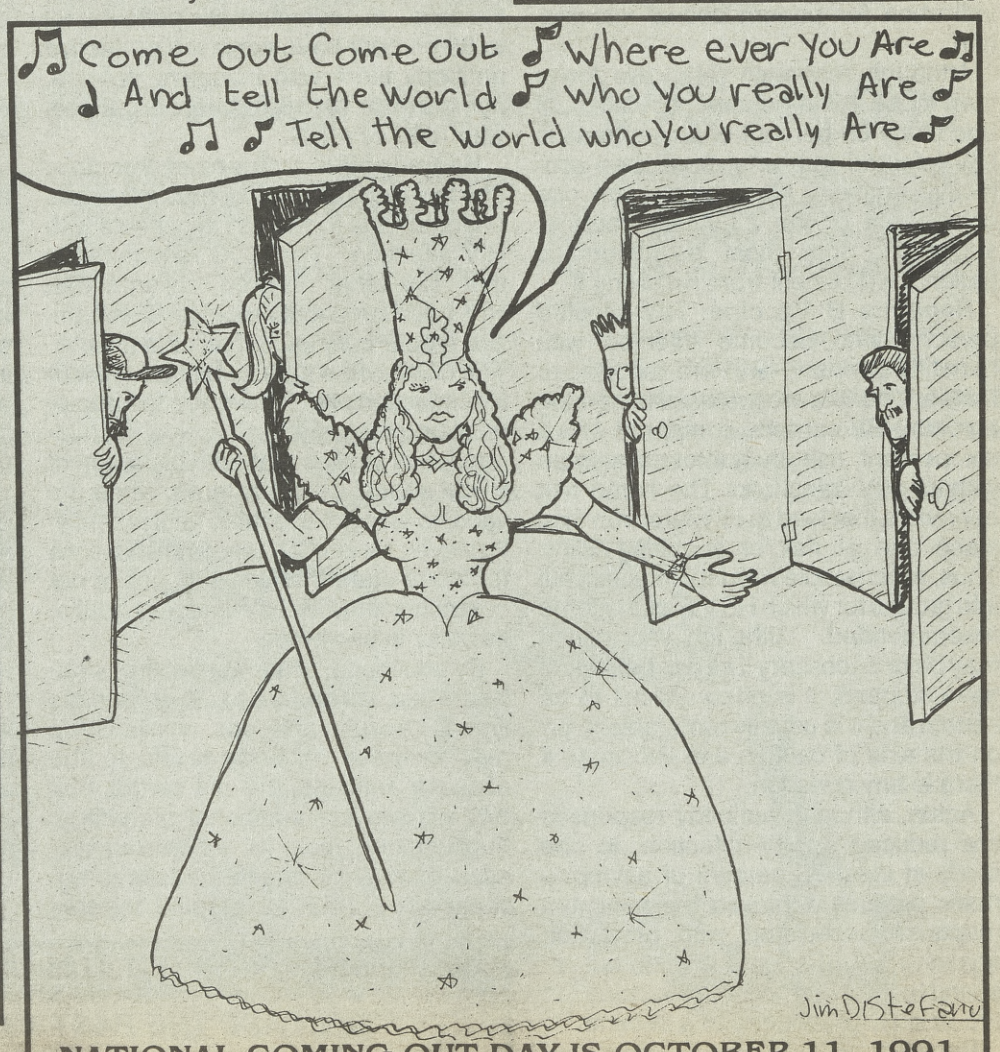
The current listing of illnesses that defines an AIDS diagnosis has long been criticized for failing to include HIV disease manifestations now known to be common among HIV-infected women and intravenous drug users with impaired immune health.

"This change is the essence of simplicity," said Dr. Gary Noble, deputy director of the CDC's division of HIV. The deputy director continued, "Immune deficiency is the underlying problem regardless of which illness or opportunistic infection arises from it."

"The revised CDC guidelines will be emotionally dramatic for people with HIV infection," stated Dr. Sandra Hernandez, director of San Francisco's Public Health AIDS Office. The director added, "Overall, hearing an AIDS diagnosis has been a positive reinforcement encouraging many individuals to adopt healthy lifestyle changes and to take action." Dr. Hernandez emphasized, "For many though, learning to accept an AIDS diagnosis remains a very difficult change and health professionals must accept and anticipate crisis intervention as people learn to cope."

The revised CDC guidelines will initiate other agencies to re-examine their own AIDS defining guidelines. Phil Gambino, spokesperson for the Social Security Administration stated that the federal agency will publish new regulations this fall eliminating automatic eligibility for individuals diagnosed with AIDS. New Social Security guidelines will dictate that anyone with an HIV-positive result and applying for benefits will be required to have a physician complete a form detailing their condition and explaining why the applicant is disabled.

According to Dr. Curran, the broader CDC definition could add 150,000 to 200,000 to the U.S. AIDS caseload. The ability to identify individuals earlier in the HIV spectrum of disease will improve their opportunities for access to available medical care and treatments as well as utilize benefits for which they are eligible to receive.



NATIONAL COMING OUT DAY IS OCTOBER 11, 1991

7th International Conference on AIDS: Vaccine Development

by Michelle Roland

Much of the 7th International Conference on AIDS was devoted to presentations about vaccine development in laboratory studies, animal models, and human trials. Although vaccines have traditionally been used to prevent uninfected individuals from acquiring a new infection, much of the HIV-related vaccine research is expected to be of use to people who are already HIV-positive.

There are currently 13 vaccines in various stages of human testing around the world, including six which are being used in HIV-positive volunteers in an attempt to produce an effective immune response against the virus. Several different approaches are being tried. The overall goal is to use a substance which resembles all or part of HIV and which the human immune system will see as foreign and thus attack. The products generated by this immune response, including antibodies and special types of activated white blood cells, would hopefully also be effective against HIV in the bloodstream, and infected cells in HIV-positive people. For a vaccine to be useful in this population, the immune response to the vaccine will have to be more effective than that which occurs in the great majority of people after HIV infection.

The substances used in the various vaccines are produced by one of the following methods. The whole virus can be killed or inactivated; the Salk HIV vaccine uses this approach. Alternatively, small portions of the virus, including parts of its outer coat (envelope), or portions of its inner (core) proteins, can be produced by genetic engineering technology. These are called the *subunit* vaccines. Another approach, using *synthetic peptides,* is also being tested; these are similar to subunit vaccines, but are smaller and produced using different techniques. (A peptide is simply a small part of a protein.) Finally, researchers are inserting the gene for one or more of these proteins into different microbes (viruses, yeast, bacteria, etc.) which then produce the protein. When these microbes, known as vectors, are injected into people, they make the HIV proteins which they were genetically engineered to produce. This approach is known as the *recombinant vector vaccine.* Combinations of these, are currently being tested.

In the United States at least five vaccine candidates are in trials separately or in combination with one another. (1) MicroGeneSys is studying a gp160 subunit vaccine called VaxSyn (gp160 is a protein which is found in the outer envelope of HIV). (2) MicroGeneSys has also produced a p24 subunit vaccine (p24 is one of the inner core proteins of HIV). (3) Bristol-Myers Squibb has a recombinant gp160 vaccine. By inserting the gene for gp160 into the vaccinia virus, the modified virus makes gp160 in the human body. (The vaccinia virus is the same one used for many years for smallpox vaccines.) (4) Viral Technologies is testing HGP-30, a synthetic peptide fragment of p17, one of the core proteins of HIV. (5) The killed-virus vaccine developed by Jonas Salk, MD, is also in U.S. human trials.

The AIDS Vaccine Evaluation Units (AVEUs) a group of five universities, are the Federal Government's primary testing sites for vaccines. They have only tested vaccines in HIV-negative volunteers so far, looking for safety data and for the degree of immune response. For information on vaccine trials in the U.S., call (800)-TRIALS-A.

Outside the U.S., the drug companies Chiron and Ciba-Geigy are jointly developing a gp120 vaccine (gp120 is another envelope protein). A French scientist Daniel Zagury, MD, from the University of Paris, is using a novel combination approach which includes some of the products discussed above, in addition to inactivated white blood cells and inactivated products of these cells, in an attempt to restore immune function.

The overall sentiment of researchers at the Florence conference can be summarized by Anthony Fauci, MD, the U.S. government's highest official AIDS researcher, from the opening session of the conference: "...Vaccine development creates an imposing challenge to the biomedical research community... Hopefully, and I am optimistic in this regard, we will witness the availability of a safe and effective vaccine against HIV in the decade of the 1990s."

-- AIDS Treatment News

Volberding: "AZT Alone May Not Be Enough"

by Sonya Cox

Dr. Paul Volberding, AIDS program director at San Francisco General Hospital, spoke at the Red Lion Inn recently to a group of Sacramento physicians and local AIDS experts on the safety and efficacy of AZT in people with HIV, and other topics of interest to the local community.

For some time it's been known that Zidovudine (AZT, also called Retrovir, and formerly called azidothymidine) can decrease the frequency and severity of opportunistic infections and the mortality rate in people who have advancing HIV disease. AZT inhibits replication of HIV and is given to people whose CD4+ cell (T-helper) counts are at 500 cells per cubic millimeter. Although not yet specifically determined, most are started on AZT when T-cells are between 500 and 200, when efficacy is at its maximum, toxicity at its minimum, and the most benefit anticipated. Volberding says that "making promising therapies available as quickly as possible while ensuring their critical assessment (via the testing and approval process) remains a special challenge."

Although benefits are clearly demonstrated with AZT, individuals have experienced anemia, neutropenia, severe nausea, and other side effects, especially in those who were taking high doses over time. Volberding said time has show that most toxicity, however, occurs within the first six months and then levels off or becomes controllable with other medications.

Volberding emphasized that we're looking at an entirely new element in the progression of this disease. We're seeing many people stay healthy for long periods of time, even after their T-cells have reached 50, which he called the "advanced stage" of disease. He said because people are staying in this group longer, anti-retroviral strategies may soon be targeted specifically at this group.

He discussed AZT resistance, saying perhaps this may be resistance to dose rather than resistance to drug. He said resistance occurs much faster in people with an AIDS diagnosis than in those with early HIV disease. Even after three years, many people with asymptomatic HIV have shown little resistance to AZT. He feels AZT should be started at 500 T-cells when people are still healthy. People with more advanced HIV disease often show some resistance as early as nine months after treatment has begun.

He notes that AZT is just as effective in women, drug users, and minorities. Gender does not seem to matter in disease progression, but people over age 35 statistically seem to progress faster than younger people with HIV. He said use of the drug above 500 T-cells is not recommended because of potential long-term toxicity.

He said he recommends taking the pills three times per day, not every four yours as was the norm a few years back, thus interrupting the sleep cycles of people who desperately needed their rest.

Current retroviral strategies include combination therapy with AZT and ddI or ddC. Therapies being considered include AZT one month, and then ddI or ddC the next. Others recommend alternating every week. And still others recommend taking both drugs daily. It will take time to discover what the right combination is, but it's now fairly clear that combination therapy as the disease progresses is preferable to using AZT alone.

He said more research needs to be done on drugs that will work at different places in the virus' infection cycle. "The more dissimilar drugs are in treating HIV at different places in the life cycle of the virus, the more effective future combination therapies will be," he said.

Volberding said he would not discourage anyone from doing combination therapy while waiting for FDA approval. He says, "If it's not approved, get it." He said that obtaining these drugs through trials is fine, but until more drugs are available by prescription, "you almost have to go to the underground -- it's a function of where we are right now in this epidemic."

He also said it's time to get rid of terminologies holding back our progress. He especially would like to see the words "AIDS" and "ARC" tossed aside. The entire HIV spectrum, he says, should be treated as one disease without differing classifications. Physicians should be allowed to treat people as they see fit no matter what is going on with that person's health.

Stages of HIV Disease	(T-cell)	Range Duration
acute syndrome	1000-500	1-4 weeks*
asymptomatic	750-200	2-15+ years
early symptomatic	500-100	1-5+ years
late symptomatic	200-50	1-4+ years
advanced disease	50-0	0-2+ years

CD4 RANGES AND DURATIONS VARIABLE

The above chart was among the slides presented by Dr. Paul Volberding. Note that the numbers overlap to a great degree so that a specific category name or duration cannot be given to any stage of the disease progression.

The 4-week acute syndrome refers to the fact that many people, upon reflection, remember suffering through a 1-4 week severe mononucleosis or flu-type illness which is now thought to occur in many people soon after initial infection, followed by a long period of time with no symptoms whatsoever (the asymptomatic stage).

Rainbow Festival Pennies Kick Off AIDS Emergency Fund

by Sonya Cox

Performing Artists for AIDS-Related Charities (PAARC), under the direction of Robert Becker, is preparing for their 1991 show, "Some People's Lives" September 19-21 at the North Sacramento School District Auditorium (see advertisement). PAARC has raised thousands of dollars over the past three years through variety shows and other events.

Preparations for PAARC's 4th Annual Show are underway. Unlike variety shows of the past, this year's show is a musical drama about how the lives of families and friends of people with HIV have been affected by the epidemic. Tickets are available at Lioness Books, Sacramento Community Center box office, and at the door on the nights of the show. The proceeds of this year's show will go to the AIDS EMERGENCY FUND.

PAARC recently announced the creation of the AIDS EMERGENCY FUND to offer direct emergency assistance to Sacramentans on disability or other subsidy programs as a result of AIDS or AIDS-Related Complex.

The Fund will provide a variety of services, including ideas on how to utilize money-saving and discounted services throughout the city that are not well advertised, a limited amount of clothing donated to PAARC by the families of Persons With AIDS lost to this disease, and direct financial support on an emergency basis. The fund will be available as soon as several thousand dollars has been raised.

"Randy Gray has undertaken the enormous job of coordinating the PENNIES FOR LIFE project, which could turn out to be one of the chief means of raising money for the Emergency Fund," says Becker. "A kickoff for this event will take place at the Rainbow Festival. We're asking everyone in Sacramento who reads about the pennies project to bring their pennies to the Rainbow Festival for our PWAs."

"The Emergency Fund over the coming years will need a continuing and growing source of financing to meet even the minimal needs of these people, and I'm looking now for a group of volunteers to work with me to get these penny jars out to local businesses in the community. We think Pennies is an untapped resource, and we're really excited about the response so far. I can't wait to see how many pennies we get at the Rainbow Festival!"

Other projects are underway to support the AIDS Emergency Fund. These include an outreach program spearheaded by Frances Wright aimed at local rotary clubs to provide AIDS information, bake sales and quilting bees. Volunteers are also developing ideas to reach out to the deaf community as well as those in retirement.

Genetics May Play Role in HIV Survival

by Arturo Jackson III

A team of Berkeley researchers have identified a genetic pattern among trial participants infected with the HIV virus for at least five years.

The researchers concluded that trial participants with a specific genetic sequence were less susceptible to progress to a full-blown AIDS diagnosis according to Jeanette Just, a researcher with the Dr. Mary Clair King's laboratory in Berkeley who presented the findings at a meeting of geneticists at the Jackson Laboratory in Bar Harbor, Maine on July 30.

Epidemiologist King, in conjunction with colleagues Leslie G. Louie and Beth Newman, analyzed the blood samples of 114 gay men in San Francisco participating in a U.C. Berkeley-based San Francisco Men's Health Study. It was determined by the researchers that among the trial participants who had been co-existing with the HIV virus for at least five years, 29 remained asymptomatic, 21 had been diagnosed with ARC (AIDS-related condition) and the remaining 64 men had been diagnosed with AIDS.

The researchers discovered that those trial participants who remained relatively healthy inherited a specific sequence of HLA (human leukocyte antigen) cell composition from each parent. The researchers also discovered that those with a different sequence of the same gene were more likely to become debilitated by the HIV virus and subsequent disease progression.

"There are some forms of these genes that are relatively protective," King reported, "Men who have them do better, those who don't go downhill quickly. The researcher added, "there is tremendous variation in how rapidly the disease progresses."

The researcher emphasized that the findings are preliminary and discouraged individuals exposed to the HIV virus from expensive "tissue typing" tests. The research team's findings may partially explain why many exposed to the HIV virus remain healthy for years and influence future anti-HIV drugs based on an individual's genetic composition.

Evidence Grows That KS is Sexually Transmitted

Kaposi's sarcoma (KS) is a malignancy seen in homosexual and bisexual men with AIDS in the US, and in heterosexuals from the Caribbean and Africa, but rarely in persons from other risk groups or areas. This has led to speculation that a sexually transmitted agent may cause KS (ACC Jun 1990, p.56). This retrospective study of 2830 AIDS patients found 566 with KS. Whereas 23 percent of homosexual or bisexual men had KS, no KS was found in intravenous drug users,hemophiliacs, transfusion recipients, or children.

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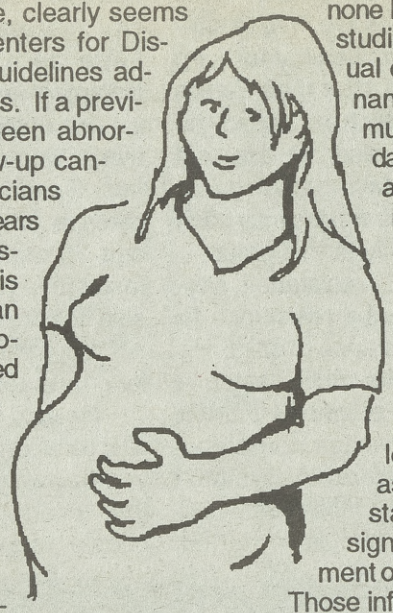
Women

Continued from page 3

infection. Although there is little information to guide the therapeutic approach to various diseases in HIV-infected women, certain strategies seem warranted by the limited data currently available.

Increased rigor in the evaluation of the cervix, for example, clearly seems indicated. Current Centers for Disease Control (CDC) guidelines advise annual Pap smears. If a previous Pap smear has been abnormal, or if annual follow-up cannot be assured, clinicians should perform Pap smears when the patient presents for care even if it is at an interval of less than a year. Some practitioners screen HIV-infected women twice annually. Similarly, an aggressive approach to colposcopic evaluation and biopsy is warranted.



Aggressive treatment for sexually transmitted diseases also seems indicated. In-hospital care of women with a diagnosis of PID, for example, is probably advisable. As discussed, the possibility of a primary HIV etiology should be entertained in the evaluation of genital ulcers. For all infections, assiduous attention should be paid to obtaining a reculture to verify that the organism has been eradicated and to treating sexual partners.

Reproductive Counseling: Gynecologic care includes the need for reproductive counseling. HIV-infected women, at least those who are asymptomatic, conceive and give birth at the same rate as seronegative women from the same risk groups. The question of who will care for the child when the HIV-infected mother no longer can should be a major focus of prenatal counseling. HIV-infected women considering pregnancy, and those who are pregnant, also need to be informed about the perinatal aspects of HIV disease.

The vertical transmission rate of HIV is between 20 and 40 percent. Although a variety of factors may modify that rate (e.g., mother's clinical status, gestational age, western blot patterns), none have been sufficiently well studied to be useful in individual counseling. While pregnancy does influence immune status, most empiric data have not demonstrated a deleterious effect of pregnancy on the natural history of HIV disease. During pregnancy, immunologic monitoring must be assiduously pursued since CD4 levels may change more rapidly in pregnant women and low levels have been shown, as in the non-pregnant state, to have prognostic significance for the development of opportunistic infections. Those infections during pregnancy can have catastrophic consequences for mother and fetus. Clinicians should, therefore, be prepared to counsel pregnant patients about the risks and benefits of various prophylactic regimens.

If, after weighing the risks and benefits, a pregnant woman chooses to receive AZT or PCP prophylaxis, ten standard treatment schedules should be followed. Most clinicians are recommending that pregnant women whose CD4 counts are under 200/mm be encouraged to receive AZT, while those with counts between 200 and 500 receive less directive counseling regarding that option. When possible, initiation therapy should be deferred until organogensis is complete (14 weeks of gestation).

Either aerosolized pentamidine or trimethoprim-sulfamethoxazole (TMP-SMX) can be used for PCP prophylaxis. Although blood levels obtained from patients receiving aerosolized pentamidine have been reassuringly low, minimizing fetal exposure, the possibility of extrapulmonary PCP exists and access to aerosolized pentamidine is not universal. TMP-SMX is a cheap, readily available, effective alternative. There are no empiric data to substantiate concerns about kernicterus resulting from in utero exposure to TMP-SMX. New, lower dose regimes (ACC Mar 1991, p.21) will further increase the margin of safety.

Although oral contraceptives may increase a woman's susceptibility to HIV infection, the possibility that they can influence the course of HIV disease remains an unsupported theoretical concern.

Conclusion

The burden of HIV disease is shifting away from white males toward minority women. Despite differences in race, gender, education, income, and drug use the guidelines used to care for these disparate populations are the same. The changing demographics of HIV disease suggest an immediate need to assess the unique ways in which women will be affected by the AIDS epidemic. In the interim, those who provide health care to women must be familiar with the importance of gynecologic health and with the need for rigor in the care of these patients.

Howard Minkoff, MD, is Director of Maternal-Fetal Medicine and a professor of obstetrics and gynecology at the SUNY Health Science Center at Brooklyn. Jack A. Dehovitz, MD, MPH, is an assistant professor of preventive medicine and Director of the AIDS Prevention Center at the same institution.

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Culture

Continued from page 3

education programs can be effective in helping reduce the potential of an epidemic. But most preventative education programs are based in schools, and high school drop-out rates exceed 50 percent on some reservations.

"Because of extreme poverty and the fact that adolescent Indians have to deal with non-Indian and Indian value systems in addition to the normal adolescence process, life can get tough really fast and tough at a young age," Charleston, a member of the Choctaw nation of Oklahoma, said.

"That may be why the American Indian population has the largest number of high school-aged youth out of school of all groups in the United States."

Previous studies have shown that young American Indians have higher patterns of early sexual activity and drug abuse than other youths. In addition, cultural practices may make them more vulnerable to AIDS.

"Health officials say more than four percent of Indian adolescents in grades seven to 12 have tried heroin compared to less than one percent of non-Indian youth," Napier, a member of the Cherokee nation of Oklahoma, said.

"This high level of substance abuse places this population at much greater risk of AIDS from injection and from unsafe sexual behaviors while under the influence of alcohol and drugs than the same-age group in the general population."

In addition, practices such a tattooing and ear piercing, not discussing human sexuality openly in the family, and practicing in traditional ceremonies, such as the Sun Dance that may involve skin punctures, place these young people even more at risk of contracting AIDS.

The Penn State researchers outlined a number of ways to implement preventative education programs that draw on the strengths of a local reservation's cultural and social structures. Those recommendations have been presented to the Centers for Disease Control and the Indian Health Service.

Some of their recommendations include establishing a nationwide American Indian AIDS advisory council with each member serving a geographical region, and selecting local advisory groups comprised of elders, students, health workers, educators, traditional medicine healers, tribal officials, and members of the target group.

The λews

In Search of a Support Group? See the Resource Guide on Pages 8-9

Routine Screen Misses Many HIV-Infected Women

The CDC and American College of Obstetricians and Gynecologists (ACOG) recommend that prenatal HIV testing be offered to women who acknowledge risk behaviors for HIV infection. This prospective study from Johns Hopkins compared these recommendations with a policy of offering HIV counseling and testing to all women registering there for prenatal care. The authors determined that had testing been restricted to those women admitting risk behaviors, only 57 percent of HIV-infected women, 87 percent of infected patients were found. The authors recommend offering routine HIV counseling and testing to all pregnant women.

A CDC study found that nearly 20,000 (2 percent) of all women tested for HIV at publicly funded voluntary counseling and testing programs during 1989 and 1990 were HIV-infected. Black and Hispanic women were disproportionately infected; HIV seroprevalence was 0.9 percent in whites, 3.3 percent in blacks, and 3.7 percent in Hispanics. Of all infected women, 35 percent reported no HIV risk behaviors. The report emphasizes the need to offer routine HIV testing and counseling to women in areas with a high prevalence of HIV infection.

-- AIDS Clinical Care

AFFIRMATION

I TRUST MY INNER WISDOM.

Helena

Continued from page 3

paradoxically, this sometimes causes the other person to distance themselves, and the harder they are pursued, the more distant they become. This can be a real dilemma, and a difficult pattern to break out of. Marriage, however, denotes a certain amount of give and take, and *you* cannot always be the one who is expected to compromise, not if your relationship is going to remain healthy and survive. If you feel this problem has become too much for the two of you to solve by yourselves, perhaps a disinterested third party might be of assistance. For example, a good couples counselor with a working knowledge of both gay couples issues, and HIV.

People who are HIV+ do sometimes become totally asexual: sometimes this is just a phase of adjustment while we take this new information into stride. Often we need to go through a period of mourning before we come to terms with news of this magnitude, and there is nothing wrong with this. Part of the challenge of being HIV+ is having to wrestle with the necessarity of not exchanging bodily fluids, without viewing sexual activity as being inherently unhealthy. Perhaps your lover is turned off by the activities he used to enjoy because he associates sex with his positive diagnosis. Perhaps he is worried about further endangering your health (or his) by re-exposing both of you to the virus. Perhaps his sex drive *has* diminished (this could be tied to any of several medications he might be taking, as well as to his general and/or emotional condition), and he is too shy or too embarrassed or too angry to admit this. If he doesn't feel comfortable talking about these issues with you, perhaps he might be willing to talk with a counselor by himself, or maybe he would benefit from a frank discussion of sexual and health issues with a gay-positive, sex-positive (and preferably gay) physician, knowledgeable about HIV.

Another suggestion would be to attend one of the HIV+ support groups and bring up this issue in group: I guarantee that you are not the only couple (positive or negative) who have struggled to resolve this question.

If the two of you cannot resolve the issue of sexual expression in the context of your relationship, perhaps you should explore what other options are available to you. Masturbation, videos, phone sex are things you might consider. Masturbation often is dismissed as an option that gets exercised only when nothing "better" is available, but it is actually a very loving and self-nurturing activity. You might consider asking your lover to hold you and caress you while you jack-off; and if you put a video in the VCR to help set the mood, who knows -- you might rekindle his interest as well. Videos certainly are available to you to watch by yourself: and while it is not the same as having physical contact, you still will be filling part of your need. (Plus, some of the new films in which they practice safer sex are *quite* fetching.)

While I certainly respect your wish to remain physically "faithful" to your lover and your marriage, there are other options that you might at least examine, even if you end up rejecting them as not for you. There are worse things than two adults arriving at some sort of "understanding" -- indeed, it could be argued that one of the advantages of being gay is being able to reexamine some of the standard issue morality in the light of what actually suits our lives and our needs. Perhaps you both might be more tolerant of your having some sort of outside sexual contact if you were to agree to some specific guidelines for such contacts. Back in the '70s many men had " - buddies" who were there for each other in the absence of lovers, tricks, what have you. Many of these buddy relationships were affectionate and satisfying, and filled a very real need for intimacy and physical contact. The '90s version of this is the safer sex buddy: given the plethora of no- or low-risk activities available these days, perhaps he is an option more of us should exercise.

I suppose the bottom line to what I am saying is this: examine your options, and be creative. After all, if our fore-fathers thought highly enough of the pursuit of happiness to write it into the Declaration of Independence (as an unalienable right, no less!) then you should have no qualms in figuring out how you are going to get some (sexual) happiness for yourself. In the immortal words of that now-classic hair products commercial, "After all -- you're *worth* it!"

With all best wishes, ever yours,
(Miss) Helena Handbasket

Wadda 'Ya Think?

Summer Lite Edition

1) Which response best describes your reactions to the last issue's ***Wadda 'Ya Think?*** column:
- __ A) Fabulous!
- __ B) Amusing
- __ C) So what?
- __ D) "Hated it"
- __ E) What column?
- __ F) Huh?

2) Which do you think is more important:
- __ A) Size
- __ B) Know-how
- __ C) Staying power
- __ D) Good kisser
- __ E) YES
- __ F) Huh?

3) Three-part question:
1) Should the accent be placed on the first syllable, as in:
- __ A) GIRL-friend!

or the second, as in:
- __ B) Girl-FRIEND!

2) Is the expression:
- __ A) "I'll be younger by lunch?"

or
- __ B) "...blonder by lunch"?

3) Whatever happened to the mythical (or at least legendary) self-styled Olympia Van Washington?

4) If you had your choice, would you rather have:
- __ A) Money, or
- __ B) Character

Why? _____

_____

5) Are most of your friends HIV+, HIV-, or do you even discuss your HIV status with your friends?

6) Do you consider that you are in the closet about your HIV status?

7) Can you put a condom on with your mouth?
__ Yes __ No
without your partner knowing?
__ Yes __ No

8) Do you believe in one-night stands?
__ Yes __ No
(or do you insist that they should come in pairs on either side of the bed?)

*Clip and send to **PSSN**, c/o LAMBDA Community Center, 1931 L St., Sacramento, 95814*

Classifieds

GWM, HIV+, 25 y/o, with brown hair, eyes, moustache-beard -- very clean cut. Enjoy a variety of interests. Let's meet to see what we have in common. Call or write (916) 441-2355 or Box 2127, Rancho Cordova, 95741.

Incarcerated GWM, HIV+, seeks sincere pen pals. Forget what you have heard about inmates. No money involved. Clyde Burgoon 2123. CMC EAST CDC# E-74818. Box 8101, San Luis Obispo, CA 93409-0001.

Handsome, professional, HIV+ GWM seeking same, 30-45 for friendship, possible relationship. Emotional stability, a positive attitude and sense of humor essential. Write to Box 162863, Sacramento, 95816.

Ads encouraging unsafe sex practices, drugs and drinking, or those containing information deemed by the Editors to be of a derogatory or discriminatory nature in terms of race, HIV status, or other similar issue, will be rejected.

Free Classified Ads Next Issue!

Print ad as follows:

_____

_____

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_____
Signature

SEND TO: PSSN Classifieds
Lambda Community Center
Box 189306
Sacramento, CA 95818

♪DANCE ♪DANCE ♪DANCE ♪DANCE ♪DANCE ♪DANCE♪

" POSITIVELY HIV "

DANCE ! DANCE !! DANCE !!!

A DANCE NIGHT ESPECIALLY FOR PEOPLE
LIVING WITH HIV
& THEIR PARTNERS OR GUESTS
DJ's FABU JORDAN & WRANGLER RICK
HI NRG/OLDIES/COUNTRY WESTERN

SEPT. 14, 1991

SATURDAY
7:30 - 11:30
GRAND BALLROOM @ RIVER CITY M.C.C.
2741 34th @ BROADWAY

$1.00 DONATION AT THE DOOR
(NO ONE WILL BE TURNED AWAY)
FREE PRIZE DRAWING & HORS D'OEURVES

♪DANCE ♪DANCE ♪DANCE ♪DANCE ♪DANCE ♪DANCE♪

P A A R C

Performing Artists for AIDS-Related Charities
4th Annual Show

"SOME PEOPLE'S LIVES"

(a musical drama)

Thurs, Sept 19: hors d'oeuvres 7 pm, show 8 pm
Fri, Sept 20, hors d'oeuvres 7 pm, show 8 pm
Sat, Sept 21, show 7 pm, hors d'oeuvres 8:30

North Sacramento School District Auditorium
670 Dixieanne Avenue
(Take 16th St to 160, 160 to Del Paso Blvd,
go 1 mile, right on Dixieanne

Tickets: $15 donation
On sale at Lioness Books, Sac Community Center box office
and at the door
Call 863-2518 Voicemail x-AIDS for further info

All ticket proceeds go directly
to Sacramentans with AIDS
needing financial assistance
thru the
AIDS EMERGENCY FUND

Thank you for your support of our Sacramento People with AIDS

Want to Stop Smoking?

Too Busy to take a 7-week clinic?
The LAMBDA Center is now offering a Self-Help Program for our community!

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* Full program packet FREE
* Bob Hall, Licensed counselor available for free individual help.
* Free drop-in support group available, when you need that extra help!

Call Sue or Ron at the Center, 442-0185 for more info or just show up any Monday at 5:30pm, 1931 L St., Sacramento